

ASCTS National Cardiac Surgery Database Program



Data Definitions Manual

Version 3

*An initiative of the Australasian Society of Cardiac and Thoracic Surgeons (ASCTS)
In association with Dept Epidemiology & Preventive Medicine, Monash University*

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Table of Contents

Introduction	10
BACKGROUND	10
OBJECTIVE	10
DATA COLLECTION	11
PROJECT MANAGEMENT	11
Data Definitions and Field Names	12
Section 1: Patient Demographics	13
PATIENT SURNAME	13
PATIENT FIRST NAME.....	13
PATIENT MIDDLE NAME	13
DATE OF BIRTH	13
GENDER	13
Section 1: Patient Demographics	14
PATIENT DOES NOT HAVE A MEDICARE NUMBER	14
MEDICARE NUMBER	14
ADDRESS	14
SUBURB.....	14
STATE.....	14
Section 1: Patient Demographics	15
PATIENT POST CODE	15
PATIENT PHONE NUMBER 1	15
PATIENT PHONE NUMBER 2	15
INDIGENOUS STATUS (1).....	15
INDIGENOUS STATUS (2).....	15
Section 1: Patient Demographics	16
INDIGENOUS STATUS (3).....	16
HOSPITAL MEDICAL RECORD NUMBER.....	16
ELECTIVE DAY OF SURGERY ADMIT (DOSA) PATIENT	16
ADMISSION DATE	16
Section 1: Patient Demographics	17
DISCHARGE DATE	17
INSURANCE	17
SURGERY DATE	17
OPERATION NUMBER.....	17
VERIFIED COMMENT.....	17
Section 2: Patient Risk Factors.....	18
SMOKING HISTORY	18
CURRENT SMOKER.....	18
FAMILY HISTORY OF CAD	18
DIABETES.....	18
Section 2: Patient Risk Factors.....	19
DIABETES – CONTROL	19
HYPERCHOLESTEROLAEMIA	19
RENAL- LAST PRE-OP CREATININE LEVEL	19
RENAL – DIALYSIS.....	19
RENAL – TRANSPLANT.....	19
Section 2: Patient Risk Factors.....	20
HYPERTENSION	20
CEREBROVASCULAR DISEASE	20
CEREBROVASCULAR DISEASE – TYPE.....	20
Section 2: Patient Risk Factors.....	21
CEREBROVASCULAR DISEASE - CVA – WHEN	21
PERIPHERAL VASCULAR DISEASE (PVD).....	21
RESPIRATORY DISEASE.....	21
RESPIRATORY DISEASE - TYPE	21

Section 2: Patient Risk Factors.....	22
INFECTIVE ENDOCARDITIS.....	22
INFECTIVE ENDOCARDITIS TYPE	22
IMMUNOSUPPRESSIVE RX	22
Section 3: Pre-Operative Cardiac Status	23
MYOCARDIAL INFARCTION (MI).....	23
MI - TYPE	23
Section 3: Pre-Operative Cardiac Status	24
MYOCARDIAL INFARCTION – WHEN	24
ANGINA – CCS CLASS CLASSIFICATION.....	24
TREATMENT OF ANGINA – i-v GTN	24
Section 3: Pre-Operative Cardiac Status	25
TREATMENT OF ANGINA – i-v HEPARIN	25
TREATMENT OF ANGINA – Full dose HEPARINOIDS.....	25
HISTORY OF CONGESTIVE HEART FAILURE	25
CHF - CHF AT CURRENT ADMISSION.....	25
Section 3: Pre-Operative Cardiac Status	26
NYHA CLASS - DYSPNOEA CLASSIFICATION	26
CARDIOGENIC SHOCK	26
RESUSCITATION (within one hour pre-op).....	26
Section 3: Pre-Operative Cardiac Status	27
ARRHYTHMIA	27
ARRHYTHMIA TYPE - ATRIAL	27
ARRHYTHMIA- ATRIAL TYPE.....	27
Section 3: Pre-Operative Cardiac Status	28
ARRHYTHMIA TYPE - HEART BLOCK	28
ARRHYTHMIA TYPE - VENTRICULAR	28
ARRHYTHMIA TYPE- OTHER.....	28
PERMAMENT PACEMAKER IN SITU.....	28
MEDICATIONS AT TIME OF SURGERY - INOTROPES	28
Section 3: Pre-Operative Cardiac Status	29
MEDICATIONS AT TIME OF SURGERY - IV NITRATES	29
MEDICATIONS AT TIME OF SURGERY - ANTICOAGULATION THERAPY	29
MEDICATIONS AT TIME OF SURGERY - STEROIDS	29
ASPIRIN OR OTHER ANTI-PLATELET THERAPY - ASPIRIN	29
ASPIRIN OR OTHER ANTI-PLATELET THERAPY – CLOPIDOGREL (Ticlodipine).....	29
Section 3: Pre-Operative Cardiac Status	30
ASPIRIN OR OTHER ANTI-PLATELET THERAPY – IIb/IIIa blockade	30
AGGROSTAT (Tyrofiban)	30
ASPIRIN OR OTHER ANTI-PLATELET THERAPY – OTHER	30
ASPIRIN - WHEN.....	30
CLOPIDOGREL - WHEN	30
Section 3: Pre-Operative Cardiac Status	31
IIb/IIIa blockade – WHEN.....	31
AGGROSTAT – WHEN.....	31
OTHER - WHEN.....	31
Section 4: Previous Interventions.....	32
PREVIOUS CARDIOTHORACIC INTERVENTION (surgical or percutaneous)	32
NUMBER OF PRIOR CARDIAC OPERATIONS REQUIRING CARDIOPULMONARY BYPASS	32
NUMBER OF PRIOR CARDIAC OPERATIONS WITHOUT CARDIOPULMONARY BYPASS (BEATING HEART SURGERY).....	32
TYPES OF PREVIOUS SURGERY- CABG.....	32
TYPES OF PREVIOUS SURGERY- OFF-PUMP CABG	32
Section 4: Previous Interventions.....	33
TYPES OF PREVIOUS SURGERY- VALVE	33
TYPES OF PREVIOUS SURGERY- OTHER CARDIAC.....	33
PREVIOUS PERCUTANEOUS INTERVENTION -PTCA/STENT	33
PTCA/STENT- FOR WHICH ADMISSION	33
PTCA/STENT- INTERVAL (if same admission).....	33
Section 4: Previous Interventions.....	34
PREVIOUS PERCUTANEOUS INTERVENTION -THROMBOLYSIS (if same admission)	34
PREVIOUS PERCUTANEOUS INTERVENTION – NON SURGICAL BALLOON VALVULOPLASTY.....	34

PREVIOUS PERCUTANEOUS INTERVENTION – ASD DEVICE CLOSURE	34
PREVIOUS PERCUTANEOUS INTERVENTION – VSD DEVICE CLOSURE	34
Section 4: Previous Interventions.....	35
PERCUTANEOUS SVT/VT ABLATION.....	35
Section 5: Haemodynamic Data	36
HEIGHT	36
WEIGHT	36
CARDIAC CATHETERIZATION (ANGIOGRAM OR PRESSURE STUDY)	36
DATE OF CARDIAC CATHETERIZATION	36
Section 5: Haemodynamic Data	37
LVEF METHOD	37
EF	37
EF ESTIMATE	37
LEFT MAIN STENOSIS > 50%	37
Section 5: Haemodynamic Data	38
NUMBER DISEASED CORONARY SYSTEMS	38
Section 6: Operative Status/Category	39
CONSULTANT SURGEON	39
OPERATING SURGEON (PROCEDURALIST).....	39
STATUS.....	39
DIRECT TRANSFER FROM CATH LAB TO THEATRE	39
Section 6: Operative Status/Category	40
CORONARY ARTERY BYPASS	40
VALVE SURGERY	40
OTHER CARDIAC SURGERY	40
LV ANEURYSM.....	40
Section 6: Operative Status/Category	41
ASD	41
TRAUMA.....	41
OTHER	41
LVOT MYECTOMY FOR HOCM	41
LV RUPTURE REPAIR	41
Section 6: Operative Status/Category	42
PULMONARY THROMBO-ENDARTERECTOMY	42
LEFT VENTRICULAR RECONSTRUCTION	42
PULMONARY EMBOLECTOMY	42
CARDIAC TUMOUR	42
Section 6: Operative Status/Category	43
CARDIAC TRANSPLANT	43
OTHER CONGENITAL.....	43
PERMANENT LV EPICARDIAL LEAD.....	43
ATRIAL ARRHYTHMIA SURGERY.....	43
Section 6: Operative Status/Category	44
ATRIAL ARRHYTHMIA SURGERY- LESION SET.....	44
ATRIAL ARRHYTHMIA SURGERY- ENERGY SOURCE.....	44
AORTIC PROCEDURE	44
Section 6: Operative Status/Category	45
AORTIC ANEURYSM.....	45
AORTIC ANEURYSM TYPE - ASCENDING	45
AORTIC ANEURYSM TYPE - ARCH.....	45
AORTIC ANEURYSM TYPE - DESCENDING.....	45
AORTIC ANEURYSM TYPE – THOR/ABD.....	45
Section 6: Operative Status/Category	46
AORTIC DISSECTION	46
AORTIC DISSECTION – TYPE	46
AORTIC DISSECTION – WHEN.....	46
ACUTE TRAUMATIC AORTIC TRANSECTION	46
OTHER NON CARDIAC PROCEDURE	46
Section 6: Operative Status/Category	47
CAROTID ENDARTERECTOMY	47
LUNG RESECTION	47
OTHER VASCULAR SURGERY	47

OTHER THORACIC SURGERY	47
OTHER	47
Section 7: Minimally Invasive.....	48
MINIMALLY INVASIVE TECHNIQUE ATTEMPTED	48
MINIMALLY INVASIVE TECHNIQUE - INDICATION	48
PERFORMED OFF PUMP.....	48
ROBOTICALLY ASSISTED	48
Section 8: CPB and Support.....	49
CARDIOPULMONARY BYPASS USED	49
CARDIOPLEGIA.....	49
CUMULATIVE CROSS CLAMP TIME	49
CUMULATIVE CARDIOPULMONARY BYPASS TIME (PERFUSION TIME).....	49
IABP	49
Section 8: CPB and Support.....	50
IABP - WHEN INSERTED.....	50
IABP – INDICATION	50
ROTA-PUMP.....	50
ROTA-PUMP - WHEN.....	50
Section 8: CPB and Support.....	51
OTHER MECHANICAL SUPPORT- VENTRICULAR ASSIST DEVICE	51
OTHER MECHANICAL SUPPORT- VENTRICULAR ASSIST DEVICE - WHEN.....	51
OTHER MECHANICAL SUPPORT- VENTRICULAR ASSIST DEVICE – INDICATION	51
Section 8: CPB and Support.....	52
INTRA-OPERATIVE TOE	52
INTRA-OPERATIVE TOE - TYPE	52
INTRA-OPERATIVE ANTIFIBRINOLYTIC USE	52
INTRA-OPERATIVE ANTIFIBRINOLYTIC USE- TYPE	52
Section 9: Coronary Bypass.....	53
INTRA-OPERATIVE DECISION TO GRAFT CORONARY ARTERY	53
IMA USED	53
IMA USED - LIMA (LEFT)	53
IMA USED – RIMA (RIGHT).....	53
NUMBER OF DISTAL ARTERIAL GRAFTS (DISTAL ANASTOMOSES WITH ARTERIAL CONDUITS).....	53
Section 9: Coronary Bypass.....	54
NUMBER OF IMA DISTAL ANASTOMOSES	54
NUMBER OF RA CONDUITS HARVESTED	54
NUMBER OF RADIAL DISTAL ANASTOMOSES.....	54
NUMBER OF VEIN DISTAL ANASTOMOSES.....	54
NUMBER OF GEPA DISTAL ANASTOMOSES	54
Section 9: Coronary Bypass.....	55
WERE ARTERIAL T-GRAFT OR Y-GRAFTS USED?.....	55
NUMBER OF DISTAL ANASTOMOSES	55
Section 10: Valve Surgery.....	56
AORTIC VALVE PROCEDURE	56
AORTIC VALVE PROSTHESIS – IMPLANT – Manufacturer’s model number.....	56
AORTIC VALVE PROSTHESIS – IMPLANT – Serial number.....	56
AORTIC VALVE PROSTHESIS – IMPLANT - SIZE	56
AORTIC VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number.....	56
Section 10: Valve Surgery.....	57
AORTIC VALVE PROSTHESIS – EXPLANT - Serial number.....	57
AORTIC VALVE PROSTHESIS – EXPLANT - SIZE	57
AORTIC STENOSIS	57
AORTIC REGURGITATION / INSUFFICIENCY.....	57
AORTIC VALVE PATHOLOGY / AETIOLOGY.....	57
Section 10: Valve Surgery.....	58
MITRAL VALVE PROCEDURE.....	58
MITRAL VALVE PROSTHESIS - IMPLANT – Manufacturer’s model number	58
MITRAL VALVE PROSTHESIS – IMPLANT – Serial number.....	58
MITRAL VALVE PROSTHESIS – IMPLANT - SIZE.....	58
MITRAL VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number	58
Section 10: Valve Surgery.....	59
MITRAL VALVE PROSTHESIS – EXPLANT - Serial number.....	59

MITRAL VALVE PROSTHESIS – EXPLANT - SIZE	59
MITRAL STENOSIS.....	59
MITRAL REGURGITATION / INSUFFICIENCY	59
MITRAL VALVE PATHOLOGY / AETIOLOGY	59
Section 10: Valve Surgery.....	60
TRICUSPID VALVE PROCEDURE.....	60
TRICUSPID VALVE PROSTHESIS – IMPLANT – Manufacturer’s model number	60
TRICUSPID VALVE PROSTHESIS – IMPLANT – Serial number	60
TRICUSPID VALVE PROSTHESIS – IMPLANT - SIZE	60
TRICUSPID VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number	60
Section 10: Valve Surgery.....	61
TRICUSPID VALVE PROSTHESIS – EXPLANT - Serial number	61
TRICUSPID VALVE PROSTHESIS – EXPLANT - SIZE	61
TRICUSPID STENOSIS.....	61
TRICUSPID REGURGITATION / INSUFFICIENCY	61
TRICUSPID VALVE PATHOLOGY / AETIOLOGY	61
Section 10: Valve Surgery.....	62
PULMONARY VALVE PROCEDURE	62
PULMONARY VALVE PROSTHESIS - IMPLANT – Manufacturer’s model number	62
PULMONARY VALVE PROSTHESIS – IMPLANT - Serial number	62
PULMONARY VALVE PROSTHESIS – IMPLANT - SIZE	62
PULMONARY VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number.....	62
Section 10: Valve Surgery.....	63
PULMONARY VALVE PROSTHESIS – EXPLANT - Serial number	63
PULMONARY VALVE PROSTHESIS – EXPLANT - SIZE	63
PULMONARY STENOSIS	63
PULMONARY REGURGITATION / INSUFFICIENCY.....	63
PULMONARY VALVE PATHOLOGY / AETIOLOGY.....	63
Section 11. Post-Operative Data.....	64
BLOOD BANK PRODUCTS - RBC.....	64
BLOOD BANK PRODUCTS - NON RBC.....	64
PERIOPERATIVE TRANSFUSION- BANK RBC	64
PERIOPERATIVE TRANSFUSION- PLATELETS	64
PERIOPERATIVE TRANSFUSION- NOVO 7.....	64
Section 11. Post-Operative Data.....	65
PERIOPERATIVE TRANSFUSION- FFP	65
PERIOPERATIVE TRANSFUSION- CRYO	65
ICU ADMISSION – DATE/TIME.....	65
ICU DISCHARGE - DATE/TIME	65
EXTUBATION - DATE/TIME	65
Section 11. Post-Operative Data.....	66
READMITTED TO ICU	66
REINTUBATION.....	66
REINTUBATION - DATE/TIME	66
RE-EXTUBATION - DATE/TIME.....	66
ICC LOSS (FIRST 4 HOURS POST SURGERY).....	66
Section 11. Post-Operative Data.....	67
Complications.....	67
RETURN TO THEATRE	67
RE-OP VALVE DYSFUNCTION	67
RE-OP BLEEDING/TAMPONADE.....	67
RE-OP GRAFT OCCLUSION.....	67
Section 11. Post-Operative Data.....	68
Complications.....	68
RE-OP DEEP STERNAL INFECTION	68
RE-OP OTHER CARDIAC	68
RE-OP OTHER NON CARDIAC	68
NEW RENAL FAILURE	68
HAEMOFILTRATION.....	68
Section 11. Post-Operative Data.....	69
Complications.....	69
HIGHEST POST-OP CREATININE LEVEL	69

PERI-OPERATIVE AMI	69
PERI-OPERATIVE CARDIOGENIC SHOCK	69
CARDIAC INOTROPE USE – FOR LONGER THAN 4 HOURS POST-OPERATIVELY	69
Section 11. Post-Operative Data	70
Complications.....	70
CARDIAC INOTROPE USE – FOR LOW CARDIAC OUTPUT SYNDROME.....	70
CARDIAC INOTROPE USE – FOR LOW SVR SYNDROME.....	70
NEW CARDIAC ARRHYTHMIA.....	70
NEW HEART BLOCK (REQUIRING PPM)	70
Section 11. Post-Operative Data	71
Complications.....	71
CARDIAC ARREST	71
ATRIAL FIBRILLATION OR FLUTTER.....	71
NEW VENTRICULAR TACHYCARDIA.....	71
STROKE PERMANENT	71
STROKE TRANSIENT.....	71
Section 11. Post-Operative Data	72
Complications.....	72
NEW CONTINUOUS COMA \geq 24 HOURS	72
PROLONGED VENTILATION > 24 HOURS.....	72
PULMONARY EMBOLISM	72
PNEUMONIA	72
RE-INTUBATION AND VENTILATION	72
Section 11. Post-Operative Data	73
Complications.....	73
DEEP STERNAL WOUND INFECTION	73
DEEP THORACOTOMY WOUND INFECTION	73
SEPTICAEMIA.....	73
AORTIC DISSECTION	73
ACUTE LIMB ISCHAEMIA.....	73
Section 11. Post-Operative Data	74
Complications.....	74
ANTICOAGULANT COMPLICATIONS.....	74
GIT COMPLICATIONS.....	74
MULTI -SYSTEM FAILURE	74
Section 12: Mortality/Readmission.....	75
DISCHARGE.....	75
MORTALITY POST-DISCHARGE	75
MORTALITY - DATE.....	75
MORTALITY - LOCATION.....	75
Section 12: Mortality/Readmission.....	76
MORTALITY - PRIMARY CAUSE	76
MORTALITY - SUBSEQUENT CAUSE	76
Section 12: Mortality/Readmission.....	77
COGNISANT PATIENT WITHDRAWS FROM TREATMENT	77
READMISSION \leq 30 DAYS FROM SURGERY	77
READMIT REASON - ANTICOAGULANT COMPLICATION.....	77
READMIT REASON - ARRHYTHMIA	77
Section 12: Mortality/Readmission.....	78
READMIT REASON - CONGESTIVE HEART FAILURE (CHF)	78
READMIT REASON - VALVE DYSFUNCTION.....	78
READMIT REASON - PERICARDIAL EFFUSION.....	78
READMIT REASON - CARDIAC TAMPONADE	78
Section 12: Mortality/Readmission.....	79
READMIT REASON - OTHER COMPLICATION RELATED TO CARDIAC SURGERY	79
READMIT REASON - DEEP STERNAL INFECTION.....	79
READMIT REASON - INCISIONAL COMPLICATION.....	79
READMIT REASON - PNEUMONIA OR OTHER RESPIRATORY COMPLICATION.....	79
Section 12: Mortality/Readmission.....	80
READMIT REASON - MYOCARDIAL INFARCTION (MI).....	80
READMIT REASON - RECURRENT ANGINA	80
READMIT REASON - READMISSION UNRELATED TO CARDIAC SURGERY.....	80

Automatic Data (not entered on the Data Collection Form).....	81
PATIENT ID.....	81
ADMISSION ID	81
OPERATION ID.....	81
AGE.....	81
BMI	81
BSA	81
Automatic Data (not entered on the Data Collection Form).....	82
ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)	82
ANGINA – TYPE	82
PROLONGED INTUBATION	82
INTUBATION TIME (FIRST PERIOD ONLY).....	82
Automatic Data (not entered on the Data Collection Form).....	83
Number of hours in ICU (INITIAL STAY ONLY)	83
MORTALITY WITHIN 30 DAYS OF SURGERY	83
AORTIC VALVE PROSTHESIS – IMPLANT - TYPE.....	83
AORTIC VALVE PROSTHESIS – EXPLANT - TYPE.....	83
MITRAL VALVE PROSTHESIS – IMPLANT - TYPE	83
Automatic Data (not entered on the Data Collection Form).....	84
MITRAL VALVE PROSTHESIS – EXPLANT - TYPE	84
TRICUSPID VALVE PROSTHESIS – IMPLANT - TYPE	84
TRICUSPID VALVE PROSTHESIS – EXPLANT - TYPE	84
PULMONARY VALVE PROSTHESIS – IMPLANT - TYPE.....	84
PULMONARY VALVE PROSTHESIS – EXPLANT - TYPE.....	84
Database Inclusion Criteria.....	85

Introduction

Cardiac Surgery is a highly technical and specialised area of medicine, which is constantly evolving in terms of techniques, knowledge base and patient mix. Integral to this advancement is the requirement to ensure the attainment and maintenance of quality best practice, at an individual, unit, state and national level. The Australasian Society of Cardiac and Thoracic Surgeons (ASCTS) views routine systematic collection of data related to each surgical procedure and the monitoring of that data as a cornerstone of best practice. Improvement through knowledge of performance will filter through all levels of involvement in cardiac surgical management.

BACKGROUND

The ASCTS Database records details of all adult cardiac surgical procedures performed in participating units. Currently, seventeen of twenty-four Public Hospital Units are members of the Program and a further four are negotiating to join. Three private Hospital Services are also members. The hospitals participating in this stage are:

- Austin Hospital – VIC
- Geelong Hospital – VIC
- Monash Medical Centre – VIC
- Royal Melbourne Hospital – VIC
- St Vincent's Hospital – VIC
- The Alfred Hospital – VIC
- Mater Misericordiae Hospital - QLD
- Lake Macquarie Private Hospital - NSW
- Flinders Medical Centre – SA
- Canberra Hospital - ACT
- John Hunter Hospital - NSW
- Prince of Wales Hospital - NSW
- Westmead Hospital - NSW
- St George Hospital - NSW
- St Vincent's Hospital - NSW
- Liverpool Hospital - NSW
- Royal North Shore Hospital - NSW
- Royal Prince Alfred Hospital - NSW
- Cabrini Health – VIC
- Townsville Hospital – QLD

OBJECTIVE

The aims of this project are to standardize surgical and clinical data collection and to report on performance standards at the individual, unit, state and national level. This project provides the following:

- A common dataset with identical definitions of all data points.
- Collate reliable risk-adjusted data for research, risk assessment, and outcome prediction.
- Individual, unit, hospital and state performance.

- Improve quality of patient care through developing an effective peer review mechanism.
- At institutional level, provide a core data set for in-house mortality and morbidity review.
- Make available appropriate information for external research purposes.

DATA COLLECTION

A paper-based method of collection is used by way of the standard data collection form shown in this booklet. Data is entered and transmitted via a secure online web-based system. Data management and analysis, and Database development are provided by the Monash University, Department of Epidemiology & Preventive Medicine (DEPM).

PROJECT MANAGEMENT

Supervision of this project is governed through a panel consisting of the following persons:

Mr Gil Shardey	ASCTS (Monash Medical Centre) Chair
Mr Michael Yui	ASCTS (St Vincent's Hospital) Treasurer
Mr Andrew Newcomb	ASCTS (St Vincent's Hospital)
Mr Peter Skillington	ASCTS (Royal Melbourne Hospital)
Mr Morteza Mohajeri	ASCTS (Geelong Hospital)
Mr Siven Seevanayagam	ASCTS (Austin Hospital)
Mr Adrian Pick	ASCTS (The Alfred Hospital)
Mr Julian Smith	ASCTS (Monash Medical Centre)
Mr Steven McConchie	ASCTS (Vic DHS)
A/Prof. Chris Reid	DEPM (Monash University)
Dr Diem Dinh	DEPM (Monash University)

This panel meets four times per year to discuss the direction and progress of the project. It is appreciated that a great deal of effort will be required from each cardiac surgery unit, in terms of data collection, including its completeness and accuracy.

The key contact person for the data collection and analysis process is Diem Dinh, Project Manager, DEPM at Monash University. Diem can be contacted on **Toll Free 1800 998 722**. All enquires should be directed to Diem in the first instance.

Data Definitions and Field Names

Section 1: Patient Demographics

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
1	<p>NAME: PATIENT SURNAME</p> <p>Definition: The last name (surname) of the patient.</p> <p>Data: (free text)</p>	<p>Field Name: LNAME</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
2	<p>NAME: PATIENT FIRST NAME</p> <p>Definition: The first name (Christian name / Given name) of the patient.</p> <p>Data: (free text)</p>	<p>Field Name: FNAME</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
3	<p>NAME: PATIENT MIDDLE NAME</p> <p>Definition: The middle name of the patient.</p> <p>Data: (free text)</p>	<p>Field Name: MNAME</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Optional</p>
4	<p>NAME: DATE OF BIRTH</p> <p>Definition: The date of birth of the patient.</p> <p>Data: (Before system date)</p>	<p>Field Name: DOB</p> <p>Field Type: DATE</p> <p>Format: DD/MM/YYYY</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
5	<p>NAME: GENDER</p> <p>Definition: The sex of the patient.</p> <p>Data: Male Female</p>	<p>Field Name: SEX</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Male 2 = Female</p> <p>Constraints: Compulsory field</p>

Section 1: Patient Demographics

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
6	<p>NAME: PATIENT DOES NOT HAVE A MEDICARE NUMBER</p> <p>Definition: Colour the box on the form if the patient is not registered with Medicare (eg. Overseas patient)</p> <p>Data:</p>	<p>Field Name: NOMEDC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = not registered 0 = registered</p> <p>Constraints: Must not be Null if MEDC = Null</p>
7	<p>NAME: MEDICARE NUMBER</p> <p>Definition: The Full Medicare number of the patient (i.e. family number plus person number) if the patient is registered with Medicare</p> <p>Data:</p>	<p>Field Name: MEDC</p> <p>Field Type: NUMERIC</p> <p>Format: NNNNNNNNNN</p> <p>Codes:</p> <p>Constraints: Must not be Null if NOMEDC = 0 Must be Null if NOMEDC = 1</p>
8	<p>NAME: ADDRESS</p> <p>Definition: The Street Number, Name and Type of the patient's residential address</p> <p>Data:</p>	<p>Field Name: ADDRESS</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
9	<p>NAME: SUBURB</p> <p>Definition: The Suburb of the patient's residence</p> <p>Data: Select from the list</p>	<p>Field Name: SUBURB</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
10	<p>NAME: STATE</p> <p>Definition: The State of the patient's residence</p> <p>Data: Select from the list</p>	<p>Field Name: STATE</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>

Section 1: Patient Demographics

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
11	<p>NAME: PATIENT POST CODE</p> <p>Definition: The Post Code of the patient's residence.</p> <p>Data: Select from the list</p>	<p>Field Name: PCODE</p> <p>Field Type: NUMERIC</p> <p>Format: NNNN</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
12	<p>NAME: PATIENT PHONE NUMBER 1</p> <p>Definition: The Contact Phone Number of the patient.</p> <p>Data:</p>	<p>Field Name: PHONE1</p> <p>Field Type: TEXT</p> <p>Format: Plus sign (+) and Number of length 15</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
13	<p>NAME: PATIENT PHONE NUMBER 2</p> <p>Definition: The Contact Phone Number of the patient.</p> <p>Data:</p>	<p>Field Name: PHONE2</p> <p>Field Type: TEXT</p> <p>Format: Plus sign (+) and Number of length 15</p> <p>Codes:</p> <p>Constraints: Optional</p>
14	<p>NAME: INDIGENOUS STATUS (1)</p> <p>Definition: Is the patient Aboriginal and/or Torres Strait Islander?</p> <p>Data: Yes No</p>	<p>Field Name: RACE1</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
15	<p>NAME: INDIGENOUS STATUS (2)</p> <p>Definition: Does racial group include Aboriginal?</p> <p>Data: Aboriginal</p>	<p>Field Name: RACE2</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if RACE1 = 1</p>

Section 1: Patient Demographics

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
16	<p>NAME: INDIGENOUS STATUS (3)</p> <p>Definition: Does racial group include Torres Strait Islander?</p> <p>Data: Torres Strait Islander</p>	<p>Field Name: RACE3</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must be Null if RACE1 = 1</p>
17	<p>NAME: HOSPITAL MEDICAL RECORD NUMBER</p> <p>Definition: Patient medical record number at the hospital where surgery occurred.</p> <p>Data: (free text)</p>	<p>Field Name: UR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
18	<p>NAME: ELECTIVE DAY OF SURGERY ADMIT (DOSA) PATIENT</p> <p>Definition: Patient admitted for scheduled elective procedure on same day as procedure. [Day of admission into acute hospital in which surgery is to be performed- thus patients admitted to Medihotel the night prior to surgery may still qualify as DOSA patients].</p> <p>Data: Yes No</p>	<p>Field Name: DOSA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
19	<p>NAME: ADMISSION DATE</p> <p>Definition: Date Patient admitted/transferred to hospital where surgery performed.</p> <p>Data: (Before system date)</p>	<p>Field Name: DOA</p> <p>Field Type: DATE</p> <p>Format: DD/MM/YYYY</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>

Section 1: Patient Demographics

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS																		
20	<p>NAME: DISCHARGE DATE</p> <p>Definition: Date Patient discharged from being an inpatient at the hospital where the procedure was performed. Discharge to Hospital in the Home, rehabilitation hospital or unit or to a local referring hospital is considered as discharge from hospital.</p> <p>Data: (After Admission date and before system date)</p>	<p>Field Name: DOD</p> <p>Field Type: DATE</p> <p>Format: DD/MM/YYYY</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>																		
21	<p>NAME: INSURANCE</p> <p>Definition: Select the category which most accurately describes the patient's insurance status:</p> <p>Data:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Private</td> <td>Patient has private health insurance</td> </tr> <tr> <td>DVA</td> <td>Patient is funded by Department of Veteran Affairs</td> </tr> <tr> <td>Self-Insured</td> <td>Patient is self-funded (private patient without private health insurance)</td> </tr> <tr> <td>Overseas</td> <td>patient is an overseas visitor</td> </tr> <tr> <td>Medicare</td> <td>patient is funded by Medicare</td> </tr> <tr> <td>Other</td> <td>all other payment classes (eg TAC, Australian Military, Seamen, Work cover)</td> </tr> </table>	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>Field Name: INSUR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes:</p> <table style="width: 100%; border: none;"> <tr><td>1 = Private</td></tr> <tr><td>2 = DVA</td></tr> <tr><td>3 = Medicare</td></tr> <tr><td>4 = Self-insured</td></tr> <tr><td>5 = Overseas</td></tr> <tr><td>6 = Other</td></tr> </table> <p>Constraints: Compulsory field</p>	1 = Private	2 = DVA	3 = Medicare	4 = Self-insured	5 = Overseas	6 = Other
Private	Patient has private health insurance																			
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1 = Private																				
2 = DVA																				
3 = Medicare																				
4 = Self-insured																				
5 = Overseas																				
6 = Other																				
22	<p>NAME: SURGERY DATE</p> <p>Definition: Date on which the first surgical incision was made for the current Cardiac Surgical Procedure</p> <p>Data: (Before system date)</p>	<p>Field Name: DOP</p> <p>Field Type: DATE</p> <p>Format: DD/MM/YYYY</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>																		
23	<p>NAME: OPERATION NUMBER</p> <p>Definition: Number of operation(s) done on the day for this patient</p> <p>Data: 1st, 2nd ...6th</p>	<p>Field Name: PROCNO</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1-6</p> <p>Constraints: Compulsory field</p>																		
24	<p>NAME: VERIFIED COMMENT</p> <p>Definition: Comment of verification on surgery</p> <p>Data:</p>	<p>Field Name: VerifiedComment</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Optional</p>																		

Section 2: Patient Risk Factors

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
25	<p>NAME: SMOKING HISTORY</p> <p>Definition: A history confirming any form of tobacco use in the past</p> <p>Data: Yes No</p>	<p>Field Name: SMO_H</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
26	<p>NAME: CURRENT SMOKER</p> <p>Definition: Patients having smoked cigarettes within one month of surgery are considered to be current smokers.</p> <p>Data: Yes No</p>	<p>Field Name: SMO_C</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if SMO_H = 1</p>
27	<p>NAME: FAMILY HISTORY OF 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: 20px;">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>	<p>Field Name: FHCAD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -2 = Undiscovered</p> <p>Constraints: Compulsory field</p>
28	<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>Field Name: DB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 2: Patient Risk Factors

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
29	<p>NAME: DIABETES – CONTROL</p> <p>Definition: Method of diabetic control, at time of intervention. The most aggressive therapy should be indicated as per the following order: insulin > oral > diet. Section requirement 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 of above with insulin)</p>	<p>Field Name: DB_CON</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = None 2 = Diet 3 = Oral 4 = Insulin</p> <p>Constraints: Must not be Null if DB = 1</p>
30	<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/L, HDL <1.0 mmol/L or Triglycerides >2.0 mmol/L.</p> <p>Data: Yes No</p>	<p>Field Name: HCHOL</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
31	<p>NAME: RENAL- LAST PRE-OP CREATININE LEVEL</p> <p>Definition: Last serum creatinine recorded prior to surgery.</p> <p>Data: ≥50 µmol/L to ≤ 2000 µmol/L</p>	<p>Field Name: PRECR</p> <p>Field Type: NUMERIC</p> <p>Format: NNNN</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
32	<p>NAME: RENAL – DIALYSIS</p> <p>Definition: Is the patient on dialysis pre-operatively?</p> <p>Data: Yes No</p>	<p>Field Name: DIAL</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
33	<p>NAME: RENAL – TRANSPLANT</p> <p>Definition: Did the patient have prior renal transplant?</p> <p>Data: Yes No</p>	<p>Field Name: TRANS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>

Section 2: Patient Risk Factors

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
34	<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>	<p>Field Name: HYT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
35	<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 50% diameter stenosis (equivalent to 75% cross-sectional area stenosis). <p>Data: Yes No</p>	<p>Field Name: CBVD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
36	<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:</p> <ol style="list-style-type: none"> 1. Unresponsive Coma >24 hrs: Patient experienced complete mental unresponsiveness and no evidence of psychological or physiologically appropriate responses to stimulation. 2. CVA: Patient has a history of stroke, i.e. loss of neurological function with residual symptoms >72 hours after onset. 3. RIND: Patient has a history of loss of neurological function with symptoms >24 hours after onset but with a complete return of function within 72 hours. TIA: Patient has a history of loss of neurological function that was abrupt in onset but with complete return of function within 24 hours. 4. Non-invasive/invasive carotid test with 50% diameter stenosis (equivalent to 75% cross-sectional area stenosis). 	<p>Field Name: CBVD_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Coma 2 = CVA 3 = RIND or TIA 4 = Carotid test</p> <p>Constraints: Must not be Null if CBVD = 1</p>

Section 2: Patient Risk Factors

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS								
37	<p>NAME: CEREBROVASCULAR DISEASE - 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 weeks) Remote (> 2 weeks)</p>	<p>Field Name: CVA_W</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Recent 2 = Remote</p> <p>Constraints: Must not be Null if CBVD_T = 2</p>								
38	<p>NAME: PERIPHERAL VASCULAR DISEASE (PVD)</p> <p>Definition: The patients history of PVD either aneurysmal or chronic or acute occlusion or narrowing of the arterial lumen of the aorta or extremities. Includes the following:</p> <ul style="list-style-type: none"> • claudication either with exertion or rest • amputation for arterial insufficiency • vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities • documented aortic aneurysm • documented renal artery stenosis • positive non-invasive testing documented (e.g. ankle brachial index < 0.8). <p>Data: Yes No</p>	<p>Field Name: PVD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>								
39	<p>NAME: RESPIRATORY DISEASE</p> <p>Definition: Whether the patient has chronic lung disease, and severity level according to the following classification:</p> <table style="margin-left: 20px;"> <tr> <td>No</td> <td>No disease</td> </tr> <tr> <td>Mild</td> <td>On chronic inhaled or oral bronchodilator therapy</td> </tr> <tr> <td>Moderate</td> <td>On chronic oral steroid therapy directed at lung disease</td> </tr> <tr> <td>Severe</td> <td>Room Air $pO_2 < 60$ or Room Air $pCO_2 > 50$ or mechanical ventilation for chronic lung disease</td> </tr> </table> <p>Data: Yes No</p>	No	No disease	Mild	On chronic inhaled or oral bronchodilator therapy	Moderate	On chronic oral steroid therapy directed at lung disease	Severe	Room Air $pO_2 < 60$ or Room Air $pCO_2 > 50$ or mechanical ventilation for chronic lung disease	<p>Field Name: LD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
No	No disease									
Mild	On chronic inhaled or oral bronchodilator therapy									
Moderate	On chronic oral steroid therapy directed at lung disease									
Severe	Room Air $pO_2 < 60$ or Room Air $pCO_2 > 50$ or mechanical ventilation for chronic lung disease									
40	<p>NAME: RESPIRATORY DISEASE - TYPE</p> <p>Definition: Specify if the patient has chronic lung disease, and severity level according to the following classification:</p> <table style="margin-left: 20px;"> <tr> <td>Mild</td> <td>On chronic inhaled or oral bronchodilator therapy</td> </tr> <tr> <td>Moderate</td> <td>On chronic oral steroid therapy directed at lung disease</td> </tr> <tr> <td>Severe</td> <td>Room Air $pO_2 < 60$ or Room Air $pCO_2 > 50$ or mechanical ventilation for chronic lung disease</td> </tr> </table>	Mild	On chronic inhaled or oral bronchodilator therapy	Moderate	On chronic oral steroid therapy directed at lung disease	Severe	Room Air $pO_2 < 60$ or Room Air $pCO_2 > 50$ or mechanical ventilation for chronic lung disease	<p>Field Name: LD_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 2 = Mild 3 = Moderate 4 = Severe</p> <p>Constraints: Must not be Null if LD = 1</p>		
Mild	On chronic inhaled or oral bronchodilator therapy									
Moderate	On chronic oral steroid therapy directed at lung disease									
Severe	Room Air $pO_2 < 60$ or Room Air $pCO_2 > 50$ or mechanical ventilation for chronic lung disease									

Section 2: Patient Risk Factors

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
41	<p>NAME: INFECTIVE ENDOCARDITIS</p> <p>Definition: A patient presenting with valvular disease of infectious aetiology with past or present positive blood culture, or post-operative pathology confirmation.</p> <p>Data: Yes No</p>	<p>Field Name: IE</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
42	<p>NAME: INFECTIVE ENDOCARDITIS TYPE</p> <p>Definition: Active: If the patient is currently being treated for endocarditis, the disease is considered active. Treated: 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>	<p>Field Name: IE_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Active 2 = Treated</p> <p>Constraints: Must not be Null if IE = 1</p>
43	<p>NAME: IMMUNOSUPPRESSIVE RX</p> <p>Definition: Use of any form of immunosuppressive therapy, including systemic steroid therapy equivalent to ≥ 5mg prednisolone within 30 days or less preceding the operative procedure.</p> <p>Data: Yes No</p>	<p>Field Name: IMSRX</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
44	<p>NAME: MYOCARDIAL INFARCTION (MI)</p> <p>Definition: Patient hospitalised at any time for a Myocardial Infarction documented in the medical record.</p> <p>Data: Yes No</p>	<p>Field Name: MI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
45	<p>NAME: MI - TYPE</p> <p>Definition: 1. Non ST Elevation MI (NSTEMI) Must have at least one of the following:</p> <p>A. BIOCHEMICAL indicators of myocardial necrosis</p> <ol style="list-style-type: none"> 1. Troponin T or I > the institutional decision limit on at least one occasion during the first 24 hrs after the index event. 2. CKMB >2x the upper limit of normal on one occasion during the first 24 hrs. 3. CKMB (or preferably the CKMB mass) > upper limit of normal on 2 successive samples. <p>AND one of the following:</p> <p>B. ECG CHANGES – either ST segment depression OR T-wave abnormalities OR</p> <p>C. CLINICAL ISCHAEMIC SYMPTOMS such as:</p> <ol style="list-style-type: none"> 1. Unexplained nausea or vomiting, &/or 2. Persistent SOB secondary to LVF, &/or 3. Unexplained weakness, dizziness or syncope <p>2. ST elevation MI (STEMI) Must have the following:</p> <p>A. BIOCHEMICAL indicators as for Non-STEMI. AND</p> <p>B. ECG CHANGES</p> <ol style="list-style-type: none"> 1. ST segment elevation: New or presumed new ST elevation at the J-point in two or more contiguous leads with cut-off points => 0.2 mV in leads V1, V2 or V3 OR => 0.1mV in other leads. OR 2. Development of any new Q wave in leads V1 through V3 OR a new Q wave with duration =>0.03 sec and => 1mm deep in any other two contiguous leads. <p>That is: Mere elevations of troponin I, even to the extent defined above. If unaccompanied by ECG changes or CLINICAL CONCOMITANTS as described above are NOT to be reported as MI. So that, BIOCHEMICAL CHANGES alone do not define an MI. The accuracy with which MI can be defined increases with the proximity of the MI. Therefore, episodes of MI nominated as being <6hrs, 6-24hrs, 24hrs-7days, 8-21days demand absolute accuracy. Remote MI, >21 days, are historical. It may not be possible to diagnose STEMI unless there are residual ECG changes OR an epicardial scar is seen at operation.</p>	<p>Field Name: MI_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = NSTEMI 2 = STEMI -1 = Unknown</p> <p>Constraints: Must not be Null if MI = 1</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
46	<p>NAME: MYOCARDIAL INFARCTION – 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 to 21 days >21 days</p>	<p>Field Name: MI_W</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = ≤6hrs 2 = >6hrs + <24hrs 3 = 1-7 days 4 = 8-21 days 5 = >21 days</p> <p>Constraints: Must not be Null if MI = 1</p>
47	<p>NAME: ANGINA – CCS CLASS CLASSIFICATION</p> <p>Definition: Canadian Cardiovascular Society Classification. The highest class leading to current episode of hospitalisation and/or intervention:</p> <p>Data: 0: No angina symptoms. 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>If CCS class is not available, please indicate this on the data collection form with a "N/A" (for auditing purposes) and will be recorded blank in the database.</p>	<p>Field Name: CCS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: As per data adjacent</p> <p>Constraints: Compulsory field</p>
48	<p>NAME: TREATMENT OF ANGINA – i-v GTN</p> <p>Definition: Treatment for Unstable Angina (on day of surgery) includes i-v GTN.</p> <p>Data: Yes No</p>	<p>Field Name: ANGRXG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CCS > 0</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
49	<p>NAME: TREATMENT OF ANGINA – i-v HEPARIN</p> <p>Definition: Treatment for Unstable Angina (given ≤ 12 hours prior to surgery) includes i-v Heparin.</p> <p>Data: Yes No</p>	<p>Field Name: ANGRXH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CCS > 0</p>
50	<p>NAME: TREATMENT OF ANGINA – Full dose HEPARINOIDS</p> <p>Definition: Treatment for Unstable Angina (given ≤ 24 hours prior to surgery) includes s.c. clexane at ≥ 1mgm/Kg bd (include Other low Mol. Wt. Heparinoids), if equivalent dose.</p> <p>Data: Yes No</p>	<p>Field Name: ANGRXC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CCS > 0</p>
51	<p>NAME: HISTORY OF CONGESTIVE HEART FAILURE</p> <p>Definition: Whether a physician has ever diagnosed Congestive Heart Failure (CHF) by two of the following:</p> <p style="margin-left: 20px;">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> <p>Data: Yes No</p>	<p>Field Name: CHF</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
52	<p>NAME: CHF - CHF AT 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>Field Name: CHF_C</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CHF = 1</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
53	<p>NAME: NYHA CLASS - DYSPNOEA CLASSIFICATION</p> <p>Definition: NYHA: New York Heart Association Class - the highest level leading to current episode of hospitalisation and/or procedure. (Note: Dyspnoea in a patient who has only CAD, should be considered an angina equivalent and therefore indicated by the CCS class. The NYHA class should be marked as I in such patients)</p> <p>Data: I: Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnoea. II: Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitations, or dyspnoea. 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, or dyspnoea. IV: Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency may be present even at rest. If any physical activity is undertaken, discomfort is increased.</p> <p>If the NYHA class is not available, please indicate this on the data collection form with a "N/A" (for auditing purposes) and will be recorded blank in the database.</p>	<p>Field Name: NYHA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: As per data adjacent</p> <p>Constraints: Compulsory field</p>
54	<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> <p>Clinical criteria for cardiogenic shock are: a. Hypotension (a systolic blood pressure < 90 mmHg) &/or OR CI <2.0 for at least 30 minutes OR b. the need for supportive measures to maintain a systolic pressure > or = 90 mmHg or a CI > 2.0</p> <p>Data: Yes No</p>	<p>Field Name: SHOCK</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
55	<p>NAME: RESUSCITATION (within one hour pre-op)</p> <p>Definition: The patient required cardiopulmonary resuscitation, or initiation of treatment for cardiogenic shock, within one hour before the start of the operative procedure.</p> <p>Data: Yes No</p>	<p>Field Name: RESUS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
56	<p>NAME: ARRHYTHMIA</p> <p>Definition: Was there a pre-operative arrhythmia present by clinical documentation of any one of the following:</p> <p style="margin-left: 20px;">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 (e.g. Sick Sinus Syndrome)</p> <p>Data: Yes No</p>	<p>Field Name: ARRT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
57	<p>NAME: ARRHYTHMIA TYPE - ATRIAL</p> <p>Definition: Atrial fibrillation or flutter requiring treatment.</p> <p>Data: Yes No</p>	<p>Field Name: ARRT_A</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if ARRT = 1</p>
58	<p>NAME: ARRHYTHMIA- ATRIAL TYPE</p> <p>Definition: Indicate the type of atrial fibrillation (AF):</p> <p>Data: 1. If AF terminates spontaneously, then recurrent AF is designated as paroxysmal. 2. If this arrhythmia becomes sustained but there are periods of sinus rhythm, then AF is considered persistent. 3. Permanent AF is recognized when there are no periods of sinus rhythm.</p>	<p>Field Name: ARRT_AT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Paroxysmal 2 = Persistent 3 = Permanent -1 = Unknown</p> <p>Constraints: Must not be Null if ARRT_A = 1</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
59	<p>NAME: ARRHYTHMIA TYPE - HEART BLOCK</p> <p>Definition: Complete Heart Block (AV dissociation)</p> <p>Data: Yes No</p>	<p>Field Name: ARRT_H</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if ARRT = 1</p>
60	<p>NAME: ARRHYTHMIA TYPE - VENTRICULAR</p> <p>Definition: Sustained or recurrent ventricular tachycardia or ventricular fibrillation, requiring cardioversion and/or IV therapy</p> <p>Data: Yes No</p>	<p>Field Name: ARRT_V</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if ARRT = 1</p>
61	<p>NAME: ARRHYTHMIA TYPE- OTHER</p> <p>Definition: Other arrhythmia (e.g. Sick Sinus Syndrome, Wenckebach, 2:1 Heart Block) present.</p> <p>Data: Yes No</p>	<p>Field Name: ARRT_O</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if ARRT = 1</p>
62	<p>NAME: PERMAMENT PACEMAKER IN SITU</p> <p>Definition: Patient has a permanent pacemaker implanted.</p> <p>Data: Yes No</p>	<p>Field Name: PACE</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
63	<p>NAME: MEDICATIONS AT TIME OF SURGERY - INOTROPES</p> <p>Definition: Patient on inotropes on day of surgery (on drug when entered OR), for haemodynamic support excluding renal dose Dopamine.</p> <p>Data: Yes No</p>	<p>Field Name: MEDIN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
64	<p>NAME: MEDICATIONS AT TIME OF SURGERY - IV NITRATES</p> <p>Definition: Patient on IV Nitrates on day of surgery (on drug when entered OR).</p> <p>Data: Yes No</p>	<p>Field Name: MEDNI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
65	<p>NAME: MEDICATIONS AT TIME OF SURGERY - ANTICOAGULATION THERAPY</p> <p>Definition: Patient given warfarin/heparin/low MW heparinoid ≤ 24 hours prior to surgery</p> <p>Data: Yes No</p>	<p>Field Name: MEDAC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
66	<p>NAME: MEDICATIONS AT TIME OF SURGERY - STEROIDS</p> <p>Definition: Patient given systemic steroids on day of surgery (on drug when entered OR).</p> <p>Data: Yes No</p>	<p>Field Name: MEDST</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
67	<p>NAME: ASPIRIN OR OTHER ANTI-PLATELET THERAPY - ASPIRIN</p> <p>Definition: Patient has taken aspirin in the 7 days prior to surgery. (ATACAS is to be selected for those patients involved in the ATACAS trial where use is not yet known.)</p> <p>Data: Yes No</p>	<p>Field Name: MED_ASP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No 9 = ATACAS</p> <p>Constraints: Compulsory field</p>
68	<p>NAME: ASPIRIN OR OTHER ANTI-PLATELET THERAPY – CLOPIDOGREL (Ticlopidine)</p> <p>Definition: Patient has taken clopidogrel in the 7 days prior to surgery.</p> <p>Data: Yes No</p>	<p>Field Name: MED_CLOP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
69	<p>NAME: ASPIRIN OR OTHER ANTI-PLATELET THERAPY – IIb/IIIa blockade</p> <p>Definition: Patient has taken abciximab in the 7 days prior to surgery</p> <p>Data: Yes No</p>	<p>Field Name: MED_ABCI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
70	<p>NAME: ASPIRIN OR OTHER ANTI-PLATELET THERAPY – AGGROSTAT (Tyrofiban)</p> <p>Definition: Patient has taken aggrostat therapy in the 7 days prior to surgery</p> <p>Data: Yes No</p>	<p>Field Name: MED_AGG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
71	<p>NAME: ASPIRIN OR OTHER ANTI-PLATELET THERAPY – OTHER</p> <p>Definition: Patient has taken other antiplatelet therapy in the 7 days prior to surgery.</p> <p>Data: Yes No</p>	<p>Field Name: MED_OTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
72	<p>NAME: ASPIRIN - WHEN</p> <p>Definition: Time when last documented aspirin given.</p> <p>Data: ≤ 2 days 3 to 7 days</p>	<p>Field Name: ASPdays</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = ≤ 2 days 2 = 3 – 7 days</p> <p>Constraints: Must not be Null if MED_ASP = 1</p>
73	<p>NAME: CLOPIDOGREL - WHEN</p> <p>Definition: Time when last documented clopidogrel therapy given.</p> <p>Data: ≤2 days 3 to 7 days</p>	<p>Field Name: CLOPdays</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = ≤ 2 days 2 = 3 – 7 days</p> <p>Constraints: Must not be Null if MED_CLOP = 1</p>

Section 3: Pre-Operative Cardiac Status

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
74	<p>NAME: Iib/IIla blockade – WHEN</p> <p>Definition: Time when last documented abciximab given.</p> <p>Data: ≤2 days 3 to 7 days</p>	<p>Field Name: ABCIdays</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = ≤ 2 days 2 = 3 – 7 days</p> <p>Constraints: Must not be Null if MED_ABCI = 1</p>
75	<p>NAME: AGGROSTAT – WHEN</p> <p>Definition: Time when last documented aggrostat given.</p> <p>Data: ≤2 days 3 to 7 days</p>	<p>Field Name: AGGdays</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = ≤ 2 days 2 = 3 – 7 days</p> <p>Constraints: Must not be Null if MED_AGG = 1</p>
76	<p>NAME: OTHER - WHEN</p> <p>Definition: Time when last documented other antiplatelet therapy given.</p> <p>Data: ≤2 days 3 to 7 days</p>	<p>Field Name: OTHdays</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = ≤ 2 days 2 = 3 – 7 days</p> <p>Constraints: Must not be Null if MED_OTH = 1</p>

Section 4: Previous Interventions

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
77	<p>NAME: PREVIOUS CARDIOTHORACIC INTERVENTION (surgical or percutaneous)</p> <p>Definition: Has the patient undergone any previous cardiovascular intervention, surgical or non-surgical including those done during the current admission. Includes all forms of percutaneous angioplasty and thrombolytic therapy for cardiac indications. If the patient has had for example a PTCA Stent at another hospital and was then transferred to this hospital for surgery; ie. same admission episode.</p> <p>Data: Yes No</p>	<p>Field Name: POP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory Field</p>
78	<p>NAME: NUMBER OF PRIOR CARDIAC OPERATIONS REQUIRING CARDIOPULMONARY 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>	<p>Field Name: PBYP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-9</p> <p>Constraints: Must not be Null if POP = 1</p>
79	<p>NAME: NUMBER OF PRIOR CARDIAC OPERATIONS WITHOUT CARDIOPULMONARY BYPASS (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>	<p>Field Name: PBH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-9</p> <p>Constraints: Must not be Null if POP = 1</p>
80	<p>NAME: TYPES OF PREVIOUS SURGERY- CABG</p> <p>Definition: Previous Coronary Artery Bypass surgery by any approach.</p> <p>Data: Yes No</p>	<p>Field Name: PCAB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
81	<p>NAME: TYPES OF PREVIOUS SURGERY- OFF-PUMP CABG</p> <p>Definition: Previous coronary artery bypass surgery performed without the use of cardiopulmonary bypass.</p> <p>Data: Yes No</p>	<p>Field Name: POPCAB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>

Section 4: Previous Interventions

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
82	<p>NAME: TYPES OF PREVIOUS SURGERY- VALVE</p> <p>Definition: Previous surgical replacement and/or repair of a cardiac valve, by any approach.</p> <p>Data: Yes No</p>	<p>Field Name: PVAL</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
83	<p>NAME: TYPES OF PREVIOUS SURGERY- OTHER CARDIAC</p> <p>Definition: Any other previous cardiac surgery, including operation on the ascending aorta and/or aortic arch, including pericardiectomy?</p> <p>Data: Yes No</p>	<p>Field Name: PCOP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
84	<p>NAME: PREVIOUS PERCUTANEOUS INTERVENTION - PTCA/STENT</p> <p>Definition: Was Percutaneous Transluminal Coronary Angioplasty, Coronary Atherectomy, and/or coronary Stent done <u>at any time</u> prior to this surgical procedure (which may include during the current admission)?</p> <p>Data: Yes No</p>	<p>Field Name: PCI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
85	<p>NAME: PTCA/STENT- FOR WHICH ADMISSION</p> <p>Definition: Indicate whether PTCA/STENT was done at this admission or prior admission.</p> <p>Data: This Admission Prior Admission</p>	<p>Field Name: PCI_ADM</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = This Admission 0 = Prior Admission</p> <p>Constraints: Must not be Null if PCI = 1</p>
86	<p>NAME: PTCA/STENT- INTERVAL (if same admission)</p> <p>Definition: The time between PTCA/Atherectomy/Stent and surgical repair of coronary occlusion. No. of hours <u>if during same admission</u> (includes direct transfer patients from hospital where stent was inserted to hospital where operation was performed).</p> <p>Data: No. of hours</p>	<p>Field Name: PCI_H</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Must not be Null if PCI_ADM = 1</p>

Section 4: Previous Interventions

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
87	<p>NAME: PREVIOUS PERCUTANEOUS INTERVENTION - THROMBOLYSIS (if same admission)</p> <p>Definition: Was Thrombolytic treatment given for cardiac indications at any time prior to this surgical procedure, <u>during this admission?</u> (includes direct transfer patients from hospital where thrombolysis was given to hospital where operation was performed).</p> <p>Data: Yes No</p>	<p>Field Name: THRM</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
88	<p>NAME: THROMBOLYSIS - INTERVAL</p> <p>Definition: The time between thrombolysis treatment and surgical repair of coronary occlusion. No. of hours if during same admission (includes direct transfer patients from hospital where stent was inserted to hospital where operation was performed).</p> <p>Data: No. of hours</p>	<p>Field Name: THRM_H</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Must not be Null if THRM =1</p>
89	<p>NAME: PREVIOUS PERCUTANEOUS INTERVENTION – NON SURGICAL BALLOON VALVULOPLASTY</p> <p>Definition: Has the patient had a previous non-surgical Balloon Valvuloplasty at any time?</p> <p>Data: Yes No</p>	<p>Field Name: PBALL</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
90	<p>NAME: PREVIOUS PERCUTANEOUS INTERVENTION – ASD DEVICE CLOSURE</p> <p>Definition: Closure by percutaneous technique of Atrial Septal Defect at any time</p> <p>Data: Yes No</p>	<p>Field Name: PCI_ASD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>
91	<p>NAME: PREVIOUS PERCUTANEOUS INTERVENTION – VSD DEVICE CLOSURE</p> <p>Definition: Closure by percutaneous technique of Ventricular Septal Defect, at any time</p> <p>Data: Yes No</p>	<p>Field Name: PCI_VSD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if POP = 1</p>

Section 4: Previous Interventions
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#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
92	<p>NAME: PERCUTANEOUS SVT/VT ABLATION</p> <p>Definition: Patient had percutaneous ablation procedure for any form of SVT or VT.</p> <p>Data: Yes No</p>	<p>Field Name: SVT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if POP = 1</p>

Section 5: Haemodynamic Data

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
93	<p>NAME: HEIGHT</p> <p>Definition: Height in centimetres in bare or stockinged feet.</p> <p>Data: cm</p>	<p>Field Name: HTM</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Compulsory Field</p>
94	<p>NAME: WEIGHT</p> <p>Definition: Weight in kilograms in light clothing and stockinged feet.</p> <p>Data: kg</p>	<p>Field Name: WKG</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Compulsory Field</p>
95	<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>	<p>Field Name: CATH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
96	<p>NAME: DATE OF CARDIAC CATHETERIZATION</p> <p>Definition: The date the patient had a cardiac catheter inserted.</p> <p>Data: (Before DOP date)</p> <p>Enter 09/09/9999 for unknown date Enter 01/01/2008 for known year e.g. 2008 Enter 01/03/2008 for known month e.g. March 2008</p>	<p>Field Name: CATH_W</p> <p>Field Type: DATE</p> <p>Format: DD/MM/YYYY</p> <p>Codes:</p> <p>Constraints: Must not be Null if CATH = 1</p>

Section 5: Haemodynamic Data

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS										
97	<p>NAME: LVEF METHOD</p> <p>Definition: Was the Left Ventricular Ejection Fraction measured, and how was this information obtained?</p> <p>Data: <table style="margin-left: 20px; border: none;"> <tr> <td style="padding-right: 20px;">No</td> <td>None of the following were done</td> </tr> <tr> <td>LV Gram</td> <td>Left Ventriculogram</td> </tr> <tr> <td>Radionucleotide</td> <td>Nuclear</td> </tr> <tr> <td>Echo</td> <td>Echocardiogram</td> </tr> <tr> <td>MRI</td> <td>Magnetic Resonance Imaging</td> </tr> </table> </p>	No	None of the following were done	LV Gram	Left Ventriculogram	Radionucleotide	Nuclear	Echo	Echocardiogram	MRI	Magnetic Resonance Imaging	<p>Field Name: EF_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: <ul style="list-style-type: none"> 1 = No 2 = LV Gram 3 = Radionuclide 4 = Echo 5 = MRI -1 = Unknown </p> <p>Constraints: Compulsory field</p>
No	None of the following were done											
LV Gram	Left Ventriculogram											
Radionucleotide	Nuclear											
Echo	Echocardiogram											
MRI	Magnetic Resonance Imaging											
98	<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>	<p>Field Name: EF</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5-90</p> <p>Constraints: Must not be Null if EF_T > 1</p>										
99	<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: <table style="margin-left: 20px; border: none;"> <tr> <td style="padding-right: 20px;">Normal</td> <td>(LV-EF > 60%)</td> </tr> <tr> <td>Mild Impairment</td> <td>(EF 46-60%)</td> </tr> <tr> <td>Moderate</td> <td>(EF 30-45%)</td> </tr> <tr> <td>Severe</td> <td>(EF<30%)</td> </tr> </table> </p>	Normal	(LV-EF > 60%)	Mild Impairment	(EF 46-60%)	Moderate	(EF 30-45%)	Severe	(EF<30%)	<p>Field Name: EF_EST</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: <ul style="list-style-type: none"> 1 = Normal 2 = Mild 3 = Moderate 4 = Severe </p> <p>Constraints: Must not be Null if EF_T > 1</p>		
Normal	(LV-EF > 60%)											
Mild Impairment	(EF 46-60%)											
Moderate	(EF 30-45%)											
Severe	(EF<30%)											
100	<p>NAME: LEFT MAIN STENOSIS > 50%</p> <p>Definition: Any stenosis that involves any parts of the Left Main. Left Main Coronary stenosis is present when there is > 50% compromise of vessel diameter in any angiographic view.</p> <p>Data: Yes No</p>	<p>Field Name: LMD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: <ul style="list-style-type: none"> 1 = Yes 0 = No </p> <p>Constraints: Compulsory field</p>										

Section 5: Haemodynamic Data

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
101	<p>NAME: NUMBER DISEASED CORONARY SYSTEMS</p> <p>Definition: The number of major coronary systems (LAD system, Circumflex system, and/or Right System) with > 50% narrowing in any angiographic view. The number of diseased systems should be the number of systems requiring surgical approach at that operation. NOTE: Left main disease (>50%) is counted as TWO systems (LAD and Circumflex). For example, left main and RCA would count as THREE in total. Dominant circumflex counts as TWO systems.</p> <p>If a system has been grafted previously and the graft has no haemodynamically significant stenoses, then that system is NOT counted as diseased. If a previous graft requires replacement then that system IS counted as diseased.</p> <p>This question should always be answered. Insert a 0 if there are no diseased vessel systems.</p> <p>Data: 0 – 3</p>	<p>Field Name: DISVES</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0 = None 1 = One 2 = Two 3 = Three</p> <p>Constraints: Compulsory field</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
102	<p>NAME: CONSULTANT SURGEON</p> <p>Definition: The surgeon whom is ultimately responsible for the operation.</p> <p>Data: As per individual surgeon code</p>	<p>Field Name: SURG</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
103	<p>NAME: OPERATING SURGEON (PROCEDURALIST)</p> <p>Definition: The surgeon who performs all or the majority of the "specific" part of the operation. In this context, "specific" refers to the actual coronary artery graft, valve or other cardiac procedure. Which of the following was the operating surgeon?</p> <p>Data: Consultant Senior Registrar: (FRACS) Trainee or accredited Registrar Overseas Fellow Oversight: Foreign graduate oversight supervision</p>	<p>Field Name: PROC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Consultant 2 = Senior Registrar 3 = Trainee 4 = Overseas Fellow 5 = Oversight</p> <p>Constraints: Compulsory field</p>
104	<p>NAME: STATUS</p> <p>Definition: Elective: The procedure could be Deferred without increased risk of compromised cardiac outcome.</p> <p>Data: Urgent: Not routine – medical reason for operating this admission – a) within 72 hours from angiography if on the same admission that angiography was performed (in this case, "same admission" includes the situation when angiography is performed at another hospital and the patient is transferred directly to the hospital where surgery is to be performed) OR b) within 72 hours after an unplanned admission (in a patient who had a previous angiogram and was scheduled for surgery but was admitted acutely).</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, that is, prior to surgical incision.</p>	<p>Field Name: STAT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Elective 2 = Urgent 3 = Emergency 4 = Salvage</p> <p>Constraints: Compulsory field</p>
105	<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>	<p>Field Name: DTCATH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
106	<p>NAME: CORONARY ARTERY BYPASS</p> <p>Definition: Current Surgical Procedure is Coronary Artery Bypass.</p> <p>Data: Yes No</p>	<p>Field Name: CCAB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
107	<p>NAME: VALVE SURGERY</p> <p>Definition: Current Surgical Procedure is Valve Surgery.</p> <p>Data: Yes No</p>	<p>Field Name: CVLV</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
108	<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>	<p>Field Name: COTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
109	<p>NAME: LV ANEURYSM</p> <p>Definition: Current Surgical Procedure is for Left Ventricular Aneurysm (LVA).</p> <p>Data: Yes No</p>	<p>Field Name: LVA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
110	<p>NAME: VSD (ACQUIRED)</p> <p>Definition: Current Surgical Procedure is for the correction of an acquired (usually ischaemic) Ventricular Septal Defect.</p> <p>Data: Yes No</p>	<p>Field Name: VSD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
111	<p>NAME: ASD</p> <p>Definition: Current Surgical Procedure is for the correction of an Atrial Septal Defect (Excludes closure of incidental PFO).</p> <p>Data: Yes No</p>	<p>Field Name: ASD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
112	<p>NAME: TRAUMA</p> <p>Definition: Current Surgical Procedure is for the repair of Cardiac Trauma.</p> <p>Data: Yes No</p>	<p>Field Name: TRAUMA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
113	<p>NAME: OTHER</p> <p>Definition: Current Surgical Procedure is a cardiac procedure not otherwise specified.</p> <p>Data: Yes No</p>	<p>Field Name: COTHNS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
114	<p>NAME: LVOT MYECTOMY FOR HOCM</p> <p>Definition: This procedure is performed for either hypertrophic obstructive cardiomyopathy or left ventricular muscular dynamic LVOT obstruction, or in cases of tunnel stenosis in the left ventricular outflow tract. This procedure involves excision of left ventricular endocardial muscle from the left ventricular outflow tract.</p> <p>Data: Yes No</p>	<p>Field Name: HOCM</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
115	<p>NAME: LV RUPTURE REPAIR</p> <p>Definition: This is ischaemic rupture of the free wall of the left ventricle. Therefore does not include traumatic rupture.</p> <p>Data: Yes No</p>	<p>Field Name: LVRR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
116	<p>NAME: PERICARDIECTOMY</p> <p>Definition: Current Surgical Procedure is a pericardiectomy.</p> <p>Data: Yes No</p>	<p>Field Name: PCAR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
117	<p>NAME: PULMONARY THROMBO-ENDARTERECTOMY</p> <p>Definition: Operation performed for chronic pulmonary thrombo-embolic disease. It involves cardiopulmonary bypass, and mostly hypothermic circulatory arrest, and incisions are made in the right and left (or both) pulmonary arteries, and an endarterectomy performed out into the distal branches.</p> <p>Data: Yes No</p>	<p>Field Name: PTE</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
118	<p>NAME: LEFT VENTRICULAR RECONSTRUCTION</p> <p>Definition: Reshaping of the left ventricle by lateral excision (Bastista) or antero-septal reconstruction (Dor). Does not include resection and repair of chronic left ventricular aneurysm, by whatever technique.</p> <p>Data: Yes No</p>	<p>Field Name: LVRECON</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
119	<p>NAME: PULMONARY EMBOLECTOMY</p> <p>Definition: Current surgical procedure is for pulmonary embolectomy.</p> <p>Data: Yes No</p>	<p>Field Name: PULEMB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
120	<p>NAME: CARDIAC TUMOUR</p> <p>Definition: Current Surgical Procedure is for removal of Cardiac Tumour(s).</p> <p>Data: Yes No</p>	<p>Field Name: TUMOUR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
121	<p>NAME: CARDIAC TRANSPLANT</p> <p>Definition: Current Surgical Procedure is Cardiac Transplant.</p> <p>Data: Yes No</p>	<p>Field Name: CT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
122	<p>NAME: OTHER CONGENITAL</p> <p>Definition: Current Surgical Procedure is for a congenital complication not otherwise specified.</p> <p>Data: Yes No</p>	<p>Field Name: OTHCON</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
123	<p>NAME: PERMANENT LV EPICARDIAL LEAD</p> <p>Definition: Insertion of a permanent LV Epicardial Lead in association with a cardiac procedure.</p> <p>Data: Yes No</p>	<p>Field Name: PLVEL</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>
124	<p>NAME: ATRIAL ARRHYTHMIA SURGERY</p> <p>Definition: Current surgical procedure is for paroxysmal, persistent or permanent atrial tachy arrhythmia. If Yes, completion of "Lesion Set" and "Energy Source" is compulsory.</p> <p>Data: Yes No</p>	<p>Field Name: AAS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if COTH = 1</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS																
125	<p>NAME: ATRIAL ARRHYTHMIA SURGERY- LESION SET</p> <p>Definition: Choose the ONE predominant Lesion Set from the following:</p> <p>Data:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; vertical-align: top;">Cox-Maze III</td> <td>Complete Maze III lesions as described by James Cox</td> </tr> <tr> <td style="vertical-align: top;">Radial</td> <td>Radiating lesions from the SA node as described by Nitta or Westmead group (Star)</td> </tr> <tr> <td style="vertical-align: top;">Mini-Maze</td> <td>Circumferential pulmonary veins isolation and line of conduction block in both right atrial isthmus and left atrial isthmus (including coronary sinus)</td> </tr> <tr> <td style="vertical-align: top;">Left Atrial Reduction</td> <td>Circumferential pulmonary veins isolation with excision or exclusion of cuff of atrial tissues to reduce left atrial dimensions</td> </tr> <tr> <td style="vertical-align: top;">Pulmonary Vein Isolation</td> <td>Circumferential pulmonary vein isolation only</td> </tr> <tr> <td style="vertical-align: top;">Left Atrial Only</td> <td>Left atrial component of Cox-Maze II</td> </tr> <tr> <td style="vertical-align: top;">Right Atrial only</td> <td>Right atrial component of Cox-Maze III</td> </tr> <tr> <td style="vertical-align: top;">Other</td> <td>When lesion set does not meet above definitions</td> </tr> </table>	Cox-Maze III	Complete Maze III lesions as described by James Cox	Radial	Radiating lesions from the SA node as described by Nitta or Westmead group (Star)	Mini-Maze	Circumferential pulmonary veins isolation and line of conduction block in both right atrial isthmus and left atrial isthmus (including coronary sinus)	Left Atrial Reduction	Circumferential pulmonary veins isolation with excision or exclusion of cuff of atrial tissues to reduce left atrial dimensions	Pulmonary Vein Isolation	Circumferential pulmonary vein isolation only	Left Atrial Only	Left atrial component of Cox-Maze II	Right Atrial only	Right atrial component of Cox-Maze III	Other	When lesion set does not meet above definitions	<p>Field Name: LESION1</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes:</p> <ul style="list-style-type: none"> 1 = Cox-Maze III 2 = Radial 3 = Mini-Maze 4 = Left Atrial Reduction 5 = Pulmonary Vein Isolation 6 = Left Atrial Only 7 = Right Atrial only 8 = Other <p>Constraints: Must not be Null if AAS = 1</p>
Cox-Maze III	Complete Maze III lesions as described by James Cox																	
Radial	Radiating lesions from the SA node as described by Nitta or Westmead group (Star)																	
Mini-Maze	Circumferential pulmonary veins isolation and line of conduction block in both right atrial isthmus and left atrial isthmus (including coronary sinus)																	
Left Atrial Reduction	Circumferential pulmonary veins isolation with excision or exclusion of cuff of atrial tissues to reduce left atrial dimensions																	
Pulmonary Vein Isolation	Circumferential pulmonary vein isolation only																	
Left Atrial Only	Left atrial component of Cox-Maze II																	
Right Atrial only	Right atrial component of Cox-Maze III																	
Other	When lesion set does not meet above definitions																	
126	<p>NAME: ATRIAL ARRHYTHMIA SURGERY- ENERGY SOURCE</p> <p>Definition: Choose the ONE predominant technique used of creating the lines of conduction block from the following:</p> <p>Data:</p> <ul style="list-style-type: none"> 1 = Cut & Sew 2 = Unipolar RF 3 = Bipolar RF 4 = Cryoblation 5 = Microwave 6 = Laser 7 = Ultrasound 8 = Other 	<p>Field Name: ES1</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if AAS = 1</p>																
127	<p>NAME: AORTIC PROCEDURE</p> <p>Definition: Current Surgical Surgery is Aortic Procedure.</p> <p>Data:</p> <ul style="list-style-type: none"> Yes No 	<p>Field Name: AO</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes:</p> <ul style="list-style-type: none"> 1 = Yes 0 = No <p>Constraints:</p>																

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
128	<p>NAME: AORTIC ANEURYSM</p> <p>Definition: Aortic Aneurysm repair.</p> <p>Data: Yes No</p>	<p>Field Name: AOAN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AO = 1</p>
129	<p>NAME: AORTIC ANEURYSM TYPE - ASCENDING</p> <p>Definition: Aortic Aneurysm involving the ascending aorta.</p> <p>Data: Yes No</p>	<p>Field Name: AOAN_A</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AOAN = 1</p>
130	<p>NAME: AORTIC ANEURYSM TYPE - ARCH</p> <p>Definition: Aortic Aneurysm involving the aortic arch.</p> <p>Data: Yes No</p>	<p>Field Name: AOAN_H</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AOAN = 1</p>
131	<p>NAME: AORTIC ANEURYSM TYPE - DESCENDING</p> <p>Definition: Aortic Aneurysm involving the descending thoracic aorta.</p> <p>Data: Yes No</p>	<p>Field Name: AOAN_D</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AOAN = 1</p>
132	<p>NAME: AORTIC ANEURYSM TYPE - THOR/ABD</p> <p>Definition: Aortic Aneurysm involving the thoraco-abdominal aorta.</p> <p>Data: Yes No</p>	<p>Field Name: AOAN_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AOAN = 1</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
133	<p>NAME: AORTIC DISSECTION</p> <p>Definition: Aortic Dissection repair.</p> <p>Data: Yes No</p>	<p>Field Name: AODS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AO = 1</p>
134	<p>NAME: AORTIC DISSECTION – TYPE</p> <p>Definition: Aortic dissection type. Choose one of the following:</p> <p>Data: Ascending Descending (only)</p>	<p>Field Name: AODS_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Ascending 2 = Descending</p> <p>Constraints: Must not be Null if AODS = 1</p>
135	<p>NAME: AORTIC DISSECTION – WHEN</p> <p>Definition: Was the dissection acute – occurring within last 2 weeks? Choose one of the following:</p> <p>Data: Acute (≤2 weeks) Non-Acute (>2 weeks)</p>	<p>Field Name: AODS_A</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Acute 2 = Non-acute</p> <p>Constraints: Must not be Null if AODS = 1</p>
136	<p>NAME: ACUTE TRAUMATIC AORTIC TRANSECTION</p> <p>Definition: Indication for surgery is traumatic aortic transection – occurring within last 2 weeks.</p> <p>Data: Yes No</p>	<p>Field Name: AOTS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if AO = 1</p>
137	<p>NAME: OTHER NON CARDIAC PROCEDURE</p> <p>Definition: Current Surgical Procedure is Non Cardiac.</p> <p>Data: Yes No</p>	<p>Field Name: NCOTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 6: Operative Status/Category

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
138	<p>NAME: CAROTID ENDARTERECTOMY</p> <p>Definition: Surgical removal of stenotic atheromatous plaque.</p> <p>Data: Yes No</p>	<p>Field Name: CEND</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NCOTH = 1</p>
139	<p>NAME: LUNG RESECTION</p> <p>Definition: Surgical removal of a damaged or diseased portion of a lung.</p> <p>Data: Yes No</p>	<p>Field Name: ROLU</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if NCOTH = 1</p>
140	<p>NAME: OTHER VASCULAR SURGERY</p> <p>Definition: Procedures correcting peripheral vascular occlusion.</p> <p>Data: Yes No</p>	<p>Field Name: VOTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NCOTH = 1</p>
141	<p>NAME: OTHER THORACIC SURGERY</p> <p>Definition: Procedures involving Thorax/pleura.</p> <p>Data: Yes No</p>	<p>Field Name: TOTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NCOTH = 1</p>
142	<p>NAME: OTHER</p> <p>Definition: Any other concomitant surgery not covered in the non-cardiac procedures above.</p> <p>Data: Yes No</p>	<p>Field Name: OTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if NCOTH = 1</p>

Section 7: Minimally Invasive

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
143	<p>NAME: MINIMALLY INVASIVE TECHNIQUE ATTEMPTED</p> <p>Definition: Was a non-standard incision used to minimise thoracic trauma, either for beating heart off-pump coronary artery procedure or for an on-pump cardiac procedure utilising any form of cardiopulmonary bypass?</p> <p>Data: Yes No</p>	<p>Field Name: MIN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
144	<p>NAME: MINIMALLY INVASIVE TECHNIQUE - INDICATION</p> <p>Definition: What was the indication for attempting a minimally invasive technique? Select ONE of the following:</p> <p>Data: Surgeon/Patient choice Contraindications for standard incision Combined with Catheter Intervention</p>	<p>Field Name: MIN_I</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Choice 2 = Contraindication 3 = Catheter</p> <p>Constraints: Must not be Null if MIN = 1</p>
145	<p>NAME: PERFORMED OFF PUMP</p> <p>Definition: The response to the off pump procedure question will determine the setting/response for CPBP section.</p> <p>Data: Yes No</p>	<p>Field Name: OFFP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
146	<p>NAME: ROBOTICALLY ASSISTED</p> <p>Definition: Any procedure performed with the assistance of a robot (eg. Da Vinci, AESOP).</p> <p>Data: Yes No</p>	<p>Field Name: ROBOT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 8: CPB and Support

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
147	<p>NAME: CARDIOPULMONARY BYPASS USED</p> <p>Definition: Was cardiopulmonary bypass used?</p> <p>Data: Yes No</p>	<p>Field Name: CPB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must be 1 if OFFP = 0</p>
148	<p>NAME: CARDIOPLEGIA</p> <p>Definition: Was cardioplegia used?</p> <p>Data: Yes No</p>	<p>Field Name: CPLEG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if CPB = 1</p>
149	<p>NAME: CUMULATIVE CROSS CLAMP TIME</p> <p>Definition: Total number of minutes the aorta is completely cross-clamped and the heart was ischaemic during bypass. Enter zero if no cross clamp was used.</p> <p>Data: 0 – 600 minutes</p>	<p>Field Name: CCT</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Must not be Null if CPB = 1</p>
150	<p>NAME: CUMULATIVE CARDIOPULMONARY BYPASS TIME (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>	<p>Field Name: PERF</p> <p>Field Type: NUMERIC</p> <p>Format: NNN</p> <p>Codes:</p> <p>Constraints: Must be >1 if CPB = 1</p>
151	<p>NAME: IABP</p> <p>Definition: Was the patient placed on Intra-Aortic Balloon Pump (IABP)?</p> <p>Data: Yes No</p>	<p>Field Name: IABP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>

Section 8: CPB and Support

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
152	<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>	<p>Field Name: IABP_W</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Pre-Op 2 = Intra-Op 3 = Post-Op</p> <p>Constraints: Must not be Null if IABP = 1</p>
153	<p>NAME: IABP – INDICATION</p> <p>Definition: What was the PRIMARY reason for inserting the IABP? Choose one of the following:</p> <p>Data: Haemodynamic Instability PTCA Support Unstable Angina CBP Wean: Cardiopulmonary bypass (CPB) weaning failure Prophylactic</p>	<p>Field Name: IABP_I</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Haemodynamic 2 = PTCA 3 = Angina 4 = CPB wean 5 = Prophylactic</p> <p>Constraints: Must not be Null if IABP = 1</p>
154	<p>NAME: ROTA-PUMP</p> <p>Definition: Was a Rota-pump used?</p> <p>Data: Yes No</p>	<p>Field Name: RPUMP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
155	<p>NAME: ROTA-PUMP - WHEN</p> <p>Definition: What was the time of earliest use of the rota-pump? Choose ONE of the following:</p> <p>Data: Pre-Operatively Intra-Operatively Post-Operatively</p>	<p>Field Name: RPUMP_W</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Pre-Op 2 = Intra-Op 3 = Post-Op -1 = Unknown</p> <p>Constraints: Must not be Null if RPUMP = 1</p>

Section 8: CPB and Support

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
156	<p>NAME: ROTA-PUMP – INDICATION</p> <p>Definition: What was the PRIMARY reason to use the rota-pump? Choose one of the following:</p> <p>Data: Haemodynamic Instability PTCA Support Unstable Angina CBP Wean Prophylactic</p>	<p>Field Name: PUMP_I</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Haemodynamic 2 = PTCA 3 = Angina 4 = CPB wean 5 = Prophylactic -1 = Unknown</p> <p>Constraints: Must not be Null if RPUMP = 1</p>
157	<p>NAME: OTHER MECHANICAL SUPPORT- VENTRICULAR ASSIST DEVICE</p> <p>Definition: Was a VAD/ECMO used at the time the patient left the operating room?</p> <p>Data: Yes No</p>	<p>Field Name: VAD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
158	<p>NAME: OTHER MECHANICAL SUPPORT- VENTRICULAR ASSIST DEVICE - WHEN</p> <p>Definition: What was the time of earliest use of the VAD/ECMO? Choose ONE of the following:</p> <p>Data: Pre-Operatively Intra-Operatively Post-Operatively</p>	<p>Field Name: VAD_W</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Pre-Op 2 = Intra-Op 3 = Post-Op -1 = Unknown</p> <p>Constraints: Must not be Null if VAD= 1</p>
159	<p>NAME: OTHER MECHANICAL SUPPORT- VENTRICULAR ASSIST DEVICE – INDICATION</p> <p>Definition: What was the PRIMARY reason to use the VAD/ECMO? Choose one of the following:</p> <p>Data: Haemodynamic Instability PTCA Support Unstable Angina CBP Wean Prophylactic</p>	<p>Field Name: VAD_I</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Haemodynamic 2 = PTCA 3 = Angina 4 = CPB wean 5 = Prophylactic -1 = Unknown</p> <p>Constraints: Must not be Null if VAD= 1</p>

Section 8: CPB and Support

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
160	<p>NAME: INTRA-OPERATIVE TOE</p> <p>Definition: Trans-oesophageal Echocardiography performed during cardiac surgery procedure?</p> <p>Data: Yes No</p>	<p>Field Name: IOTOE</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
161	<p>NAME: INTRA-OPERATIVE TOE - TYPE</p> <p>Definition: Indicate the insertion method.</p> <p>Data: Elective Insertion = Routine Insertion of TOE, planned before commencement of operation. Non-Elective Insertion = Unplanned insertion of TOE, for whatever reason.</p>	<p>Field Name: ELECT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Elective 0 = Non-Elective</p> <p>Constraints: Must not be Null if IOTOE = 1</p>
162	<p>NAME: INTRA-OPERATIVE ANTIFIBRINOLYTIC USE</p> <p>Definition: Antifibrinolytic used (ATACAS is to be selected for those patients involved in the ATACAS trial where use is not yet known.)</p> <p>Data: Yes No</p>	<p>Field Name: ANTIFIB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown 9 = ATACAS</p> <p>Constraints: Compulsory field</p>
163	<p>NAME: INTRA-OPERATIVE ANTIFIBRINOLYTIC USE- TYPE</p> <p>Definition: Trasylol, Tranexamic Acid or an antifibrinolytic other than Trasylol or Tranexamic Acid used peri-operatively.</p> <p>Data: Trasylol Tranexamic Acid Other</p>	<p>Field Name: ANTIFIB_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Trasylol 2 = Tranexamic Acid 3 = Other -1 = Unknown</p> <p>Constraints: Must not be Null if ANTIFIB = 1</p>

Section 9: Coronary Bypass

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
164	<p>NAME: INTRA-OPERATIVE DECISION TO GRAFT CORONARY ARTERY</p> <p>Definition: Decision made to graft coronary artery(ies) for intra-operative reasons.</p> <p>Data: Yes No</p>	<p>Field Name: IDGCA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
165	<p>NAME: IMA USED</p> <p>Definition: Was an Internal Mammary Artery Used for Coronary Bypass?</p> <p>Data: Yes No</p>	<p>Field Name: IMA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CCAB = 1</p>
166	<p>NAME: IMA USED - LIMA (LEFT)</p> <p>Definition: Was a Left Internal Mammary Artery Used for Coronary Bypass?</p> <p>Data: Yes No</p>	<p>Field Name: LIMA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if IMA = 1</p>
167	<p>NAME: IMA USED – RIMA (RIGHT)</p> <p>Definition: Was a Right Internal Mammary Artery Used for Coronary Bypass?</p> <p>Data: Yes No</p>	<p>Field Name: RIMA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if IMA = 1</p>
168	<p>NAME: NUMBER OF DISTAL ARTERIAL GRAFTS (DISTAL ANASTOMOSES WITH ARTERIAL CONDUITS)</p> <p>Definition: The total number of distal anastomoses with arterial conduits, whether IMA, GEPA, radial artery, etc.</p> <p>Data: 0 – 9</p>	<p>Field Name: DAN_AC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-9</p> <p>Constraints: Must not be Null if CCAB = 1</p>

Section 9: Coronary Bypass

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
169	<p>NAME: NUMBER OF IMA DISTAL ANASTOMOSES</p> <p>Definition: Total number of distal anastomoses done using internal mammary artery grafts.</p> <p>Data: 0 – 6</p>	<p>Field Name: DANIMA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-6</p> <p>Constraints: Must not be Null if CCAB = 1</p>
170	<p>NAME: NUMBER OF RA CONDUITS HARVESTED</p> <p>Definition: Total number of radial artery conduits used.</p> <p>Data: 0, 1, or 2</p>	<p>Field Name: RAC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-2</p> <p>Constraints: Must not be Null if CCAB = 1</p>
171	<p>NAME: NUMBER OF RADIAL DISTAL ANASTOMOSES</p> <p>Definition: Total number of radial distal anastomoses.</p> <p>Data: 0 – 6</p>	<p>Field Name: RDAN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-6</p> <p>Constraints: Must not be Null if CCAB = 1</p>
172	<p>NAME: NUMBER OF VEIN DISTAL ANASTOMOSES</p> <p>Definition: The total number of distal anastomoses with venous conduits, e.g. saphenous veins.</p> <p>Data: 0 – 9</p>	<p>Field Name: DANV</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-9</p> <p>Constraints: Must not be Null if CCAB = 1</p>
173	<p>NAME: NUMBER OF GEPA DISTAL ANASTOMOSES</p> <p>Definition: Total number of Gastro-Epiploic Artery (GEPA) distal anastomoses.</p> <p>Data: 0 – 6</p>	<p>Field Name: DANGEP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-6</p> <p>Constraints: Must not be Null if CCAB = 1</p>

Section 9: Coronary Bypass

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
174	<p>NAME: WERE ARTERIAL T-GRAFT OR Y-GRAFTS USED?</p> <p>Definition: Was any form of T or Y graft used between segments of arterial conduit?</p> <p>Data: Yes No</p>	<p>Field Name: ATY</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CCAB = 1</p>
175	<p>NAME: NUMBER OF DISTAL ANASTOMOSES</p> <p>Definition: The total number of distal anastomoses.</p> <p>Data: 0 – 9</p>	<p>Field Name: DAN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0-9</p> <p>Constraints: Must not be Null if CCAB = 1</p>

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
176	<p>NAME: AORTIC VALVE PROCEDURE</p> <p>Definition: Was a surgical procedure done on the Aortic Valve, and if so, what? Select ONE of the following:</p> <p>Data: 1: No 3: Replacement 5: Repair/Reconstruction without annuloplasty 6: Root Reconstruction with Valve Conduit (Bentall procedure) 7: Root Reconstruction with Valve Sparing (David procedure) 8: Resuspension Aortic Valve 9: Resection Sub-Aortic Stenosis 12: Repair Paravalvular leak 14: Valvotomy 15: Ross Procedure 16: Inspection only 17: Decalcification of valve only</p>	<p>Field Name: AOPROC</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if CVLV = 1</p>
177	<p>NAME: AORTIC VALVE PROSTHESIS – IMPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: AOIM</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Must not be null if AOPROC = 3, 6 or 15</p>
178	<p>NAME: AORTIC VALVE PROSTHESIS – IMPLANT – Serial number</p> <p>Data: (free text)</p>	<p>Field Name: AOIM_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints: Must not be null if AOPROC = 3, 6 or 15</p>
179	<p>NAME: AORTIC VALVE PROSTHESIS – IMPLANT - SIZE</p> <p>Definition: The size of the aortic prosthesis implant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: AOIM_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 - 50 -1 = Unknown</p> <p>Constraints: Must not be null if AOPROC = 3, 6 or 15</p>
180	<p>NAME: AORTIC VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: AOEX</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints:</p>

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
186	<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: <ul style="list-style-type: none"> 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 16: Inspection only 17: Decalcification of valve only </p>	<p>Field Name: MIPROC</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if CVLV = 1</p>
187	<p>NAME: MITRAL VALVE PROSTHESIS - IMPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: MIIM</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Must not be null if MIPROC = 2, 3, 4 or 10</p>
188	<p>NAME: MITRAL VALVE PROSTHESIS – IMPLANT – Serial number</p> <p>Data: (free text)</p>	<p>Field Name: MIIM_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints: Must not be null if MIPROC = 2, 3, 4 or 10</p>
189	<p>NAME: MITRAL VALVE PROSTHESIS – IMPLANT - SIZE</p> <p>Definition: The size of the mitral prosthesis implant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: MIIM_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 - 50 -1 = Unknown</p> <p>Constraints: Must not be null if MIPROC = 2, 3, 4 or 10</p>
190	<p>NAME: MITRAL VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: MIEX</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints:</p>

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
191	<p>NAME: MITRAL VALVE PROSTHESIS – EXPLANT - Serial number</p> <p>Data: (free text)</p>	<p>Field Name: MIEX_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints:</p>
192	<p>NAME: MITRAL VALVE PROSTHESIS – EXPLANT - SIZE</p> <p>Definition: The size of the mitral prosthesis explant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: MIEX_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 – 50 -1 = Unknown</p> <p>Constraints:</p>
193	<p>NAME: MITRAL STENOSIS</p> <p>Definition: Mitral stenosis warranting surgical correction.</p> <p>Data: Yes No</p>	<p>Field Name: MISTEN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CVLV = 1</p>
194	<p>NAME: MITRAL REGURGITATION / INSUFFICIENCY</p> <p>Definition: Is there evidence of Mitral valve regurgitation?</p> <p>Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe</p>	<p>Field Name: MIREG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if MISTEN = 1</p>
195	<p>NAME: MITRAL VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition: What is the aetiology of the mitral valve lesion?</p> <p>Data: 1 Rheumatic 14 Other degen. Disease 2 Congenital 16 Tumour 3 Ischaemic 17 Trauma 4 Idiopathic Calcific 18 Iatrogenic 5 Myxomatous degen. 19 "Functional" or 6 Failed prior repair Isolated Annular 7 Prosthetic valve failure Dilatation (Def: MR due 8 Peri-prosthetic leak to annular dilatation, 9 Prosthetic valve thrombosis without leaflet or sub- 10 Active infection valvular abnormality). 11 Previous infection 99 Other 12 Marfans</p>	<p>Field Name: MIPATH</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent -1 = Unknown</p> <p>Constraints: Must not be Null if MISTEN = 1</p>

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
196	<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) 16: Inspection only</p>	<p>Field Name: TRPROC</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if CVLV = 1</p>
197	<p>NAME: TRICUSPID VALVE PROSTHESIS – IMPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: TRIM</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Must not be null if TRPROC = 2, 3, 4 or 10</p>
198	<p>NAME: TRICUSPID VALVE PROSTHESIS – IMPLANT – Serial number</p> <p>Data: (free text)</p>	<p>Field Name: TRIM_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints: Must not be null if TRPROC = 2, 3, 4 or 10</p>
199	<p>NAME: TRICUSPID VALVE PROSTHESIS – IMPLANT - SIZE</p> <p>Definition: The size of the tricuspid prosthesis implant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: TRIM_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 -50 -1 = Unknown</p> <p>Constraints: Must not be null if TRPROC = 2, 3, 4 or 10</p>
200	<p>NAME: TRICUSPID VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: TREX</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints:</p>

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS																				
201	<p>NAME: TRICUSPID VALVE PROSTHESIS – EXPLANT - Serial number</p> <p>Data: (free text)</p>	<p>Field Name: TREX_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints:</p>																				
202	<p>NAME: TRICUSPID VALVE PROSTHESIS – EXPLANT - SIZE</p> <p>Definition: The size of the tricuspid prosthesis explant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: TREX_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 –50 -1 = Unknown</p> <p>Constraints:</p>																				
203	<p>NAME: TRICUSPID STENOSIS</p> <p>Definition: Tricuspid stenosis warranting surgical correction.</p> <p>Data: Yes No</p>	<p>Field Name: TRSTEN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CVLV = 1</p>																				
204	<p>NAME: TRICUSPID REGURGITATION / INSUFFICIENCY</p> <p>Definition: Is there evidence of Tricuspid valve regurgitation?</p> <p>Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe</p>	<p>Field Name: TRREG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if TRSTEN = 1</p>																				
205	<p>NAME: TRICUSPID VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition: What is the aetiology of the tricuspid valve lesion?</p> <p>Data:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1 Rheumatic</td> <td style="width: 50%;">11 Previous infection</td> </tr> <tr> <td>2 Congenital</td> <td>12 Marfans</td> </tr> <tr> <td>3 Ischaemic</td> <td>14 Other degen. Disease</td> </tr> <tr> <td>4 Idiopathic Calcific</td> <td>16 Tumour</td> </tr> <tr> <td>5 Myxomatous degen.</td> <td>17 Trauma</td> </tr> <tr> <td>6 Failed prior repair</td> <td>18 Iatrogenic</td> </tr> <tr> <td>7 Prosthetic valve failure</td> <td>99 Other</td> </tr> <tr> <td>8 Peri-prosthetic leak</td> <td>20 Functional</td> </tr> <tr> <td>9 Prosthetic valve thrombosis</td> <td></td> </tr> <tr> <td>10 Active infection</td> <td></td> </tr> </table>	1 Rheumatic	11 Previous infection	2 Congenital	12 Marfans	3 Ischaemic	14 Other degen. Disease	4 Idiopathic Calcific	16 Tumour	5 Myxomatous degen.	17 Trauma	6 Failed prior repair	18 Iatrogenic	7 Prosthetic valve failure	99 Other	8 Peri-prosthetic leak	20 Functional	9 Prosthetic valve thrombosis		10 Active infection		<p>Field Name: TRPATH</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent -1 = Unknown</p> <p>Constraints: Must not be Null if TRSTEN = 1</p>
1 Rheumatic	11 Previous infection																					
2 Congenital	12 Marfans																					
3 Ischaemic	14 Other degen. Disease																					
4 Idiopathic Calcific	16 Tumour																					
5 Myxomatous degen.	17 Trauma																					
6 Failed prior repair	18 Iatrogenic																					
7 Prosthetic valve failure	99 Other																					
8 Peri-prosthetic leak	20 Functional																					
9 Prosthetic valve thrombosis																						
10 Active infection																						

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
206	<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 11: Commissurotomy without annuloplasty ring 12: Repair Paravalvular leak</p>	<p>Field Name: PUPROC</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if CVLV = 1</p>
207	<p>NAME: PULMONARY VALVE PROSTHESIS - IMPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: PUIM</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints: Must not be null if PUPROC = 3</p>
208	<p>NAME: PULMONARY VALVE PROSTHESIS – IMPLANT - Serial number</p> <p>Data: (free text)</p>	<p>Field Name: PUIM_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints: Must not be null if PUPROC = 3</p>
209	<p>NAME: PULMONARY VALVE PROSTHESIS – IMPLANT - SIZE</p> <p>Definition: The size of the pulmonary prosthesis implant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: PUIM_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 – 50 -1 = Unknown</p> <p>Constraints: Must not be null if PUPROC = 3</p>
210	<p>NAME: PULMONARY VALVE PROSTHESIS - EXPLANT – Manufacturer’s model number</p> <p>Data: Select from the prosthesis list</p>	<p>Field Name: PUEX</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes:</p> <p>Constraints:</p>

Section 10: Valve Surgery

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
211	<p>NAME: PULMONARY VALVE PROSTHESIS – EXPLANT - Serial number</p> <p>Data: (free text)</p>	<p>Field Name: PUEX_SR</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: Free text -1 = Unknown</p> <p>Constraints:</p>
212	<p>NAME: PULMONARY VALVE PROSTHESIS – EXPLANT - SIZE</p> <p>Definition: The size of the pulmonary prosthesis explant.</p> <p>Data: 5 – 50 mm</p>	<p>Field Name: PUEX_S</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: 5 – 50 -1 = Unknown</p> <p>Constraints:</p>
213	<p>NAME: PULMONARY STENOSIS</p> <p>Definition: Pulmonary stenosis warranting surgical correction.</p> <p>Data: Yes No</p>	<p>Field Name: PUSTEN</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if CVLV = 1</p>
214	<p>NAME: PULMONARY REGURGITATION / INSUFFICIENCY</p> <p>Definition: Is there evidence of pulmonary valve regurgitation?</p> <p>Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe</p>	<p>Field Name: PUREG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: As per data adjacent</p> <p>Constraints: Must not be Null if PUSTEN = 1</p>
215	<p>NAME: PULMONARY VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition: What is the aetiology of the pulmonary valve?</p> <p>Data: 1 Rheumatic 11 Previous infection 2 Congenital 12 Marfans 3 Ischaemic 14 Other degen. Disease 4 Idiopathic Calcific 16 Tumour 5 Myxomatous degen. 17 Trauma 6 Failed prior repair 18 Iatrogenic 7 Prosthetic valve failure 99 Other 8 Peri-prosthetic leak 9 Prosthetic valve thrombosis 10 Active infection</p>	<p>Field Name: PUPATH</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: As per data adjacent -1 = Unknown</p> <p>Constraints: Must not be Null if PUSTEN = 1</p>

Section 11. Post-Operative Data

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
216	<p>NAME: BLOOD BANK PRODUCTS - RBC</p> <p>Definition: Were Red Blood Cells transfused intra- and/or post-operatively, that is, from the commencement of surgery to discharge?</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>	<p>Field Name: RBC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
217	<p>NAME: BLOOD BANK PRODUCTS - NON RBC</p> <p>Definition: Was a transfusion of blood products other than RBC (eg. FFP, Platelets) given intra- and/or post-operatively, that is, from the commencement of surgery to discharge? (Exclude Albumin)</p> <p>Data: Yes No</p>	<p>Field Name: NRBC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
218	<p>NAME: PERIOPERATIVE TRANSFUSION- BANK RBC</p> <p>Definition: Indicate the number of Bank RBC Units used.</p> <p>Data: No. of units</p>	<p>Field Name: RBCUnit</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: No. of units -1 = Unknown</p> <p>Constraints: Must not be Null if RBC = 1</p>
219	<p>NAME: PERIOPERATIVE TRANSFUSION- PLATELETS</p> <p>Definition: Indicate the number of Platelet Units used (not pooled bags).</p> <p>Data: No. of units</p>	<p>Field Name: PlateUnit</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: No. of units -1 = Unknown</p> <p>Constraints: Must not be Null if NRBC = 1</p>
220	<p>NAME: PERIOPERATIVE TRANSFUSION- NOVO 7</p> <p>Definition: Indicate the number of Novo 7 Units used.</p> <p>Data: No. of units</p>	<p>Field Name: NovoUnit</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: No. of units -1 = Unknown</p> <p>Constraints: Must not be Null if NRBC = 1</p>

Section 11. Post-Operative Data

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
221	<p>NAME: PERIOPERATIVE TRANSFUSION- FFP</p> <p>Definition: Indicate the number of Fresh Frozen Plasma (FFP) Units used.</p> <p>Data: No. of units</p>	<p>Field Name: FFPUnit</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: No. of units -1 = Unknown</p> <p>Constraints: Must not be Null if NRBC = 1</p>
222	<p>NAME: PERIOPERATIVE TRANSFUSION- CRYO</p> <p>Definition: Indicate the number of Cryo Units used.</p> <p>Data: No. of units</p>	<p>Field Name: CryoUnit</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes: No. of units -1 = Unknown</p> <p>Constraints: Must not be Null if NRBC = 1</p>
223	<p>NAME: ICU ADMISSION – DATE/TIME</p> <p>Definition: Indicate the date and time of admission to ICU from OR.</p> <p>Data: Date/Time Enter 09/09/9999 00:00 for unknown date/time</p>	<p>Field Name: AICU_D</p> <p>Field Type: DATE/TIME</p> <p>Format: DD/MM/YYYY HH:MM</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
224	<p>NAME: ICU DISCHARGE - DATE/TIME</p> <p>Definition: Indicate the date and time of discharge from ICU to HDU or General Ward or death.</p> <p>Data: Date/Time Enter 09/09/9999 00:00 for unknown date/time</p>	<p>Field Name: DICU_D</p> <p>Field Type: DATE/TIME</p> <p>Format: DD/MM/YYYY HH:MM</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
225	<p>NAME: EXTUBATION - DATE/TIME</p> <p>Definition: Indicate the date post-operation when the patient was extubated.</p> <p>Data: Date/Time Enter 09/09/9999 00:00 for unknown date/time</p>	<p>Field Name: EXTU_D</p> <p>Field Type: DATE/TIME</p> <p>Format: DD/MM/YYYY HH:MM</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>

Section 11. Post-Operative Data

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
226	<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>	<p>Field Name: REICU</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
227	<p>NAME: REINTUBATION</p> <p>Definition: Indicate whether the patient was reintubated during hospital stay after the initial extubation.</p> <p>Data: Yes No</p>	<p>Field Name: REINT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
228	<p>NAME: REINTUBATION - DATE/TIME</p> <p>Definition: Indicate the date and time when the patient was reintubated.</p> <p>Data: Date/Time Enter 09/09/999 00:00 for unknown date/time</p>	<p>Field Name: REINT_D</p> <p>Field Type: DATE/TIME</p> <p>Format: DD/MM/YYYY HH:MM</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
229	<p>NAME: RE-EXTUBATION - DATE/TIME</p> <p>Definition: Indicate the date and time when the patient was extubated following the reintubation.</p> <p>Data: Date/Time Enter 09/09/999 00:00 for unknown date/time</p>	<p>Field Name: REEXT_D</p> <p>Field Type: DATE/TIME</p> <p>Format: DD/MM/YYYY HH:MM</p> <p>Codes:</p> <p>Constraints: Compulsory field</p>
230	<p>NAME: ICC LOSS (FIRST 4 HOURS POST SURGERY)</p> <p>Definition: Indicate the fluid loss in mls from the Pericardial/mediastinal drains in the first 4hrs post-operation.</p> <p>Data: No. of mls</p>	<p>Field Name: DRAIN_4</p> <p>Field Type: NUMERIC</p> <p>Format: NNNN</p> <p>Codes: No. of mls -1 = Unknown</p> <p>Constraints: Compulsory field</p>

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
	NOTE	All complications must not have been present pre-operatively.
231	NAME: RETURN TO THEATRE 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. Data: Yes No	Field Name: RTT Field Type: NUMERIC Format: N Codes: 1 = Yes 0 = No Constraints: Compulsory field
232	NAME: RE-OP VALVE DYSFUNCTION Definition: Operative re-intervention was required for valve dysfunction. Data: Yes No	Field Name: ROVD Field Type: NUMERIC Format: N Codes: 1 = Yes 0 = No Constraints: Must not be Null if RTT = 1
233	NAME: RE-OP BLEEDING/TAMPONADE Definition: Operative re-intervention was required for bleeding/tamponade. Data: Yes No	Field Name: ROBL Field Type: NUMERIC Format: N Codes: 1 = Yes 0 = No Constraints: Must not be Null if RTT = 1
234	NAME: RE-OP GRAFT OCCLUSION Definition: Operative re-intervention was required to refashion a graft or graft a previously ungrafted coronary. Data: Yes No	Field Name: ROGO Field Type: NUMERIC Format: N Codes: 1 = Yes 0 = No Constraints: Must not be Null if RTT = 1

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
235	<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>	<p>Field Name: ROSI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if RTT = 1</p>
236	<p>NAME: RE-OP OTHER CARDIAC</p> <p>Definition: Operative re-intervention was required for other cardiac reasons.</p> <p>Data: Yes No</p>	<p>Field Name: ROOC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if RTT = 1</p>
237	<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>	<p>Field Name: RONC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if RTT = 1</p>
238	<p>NAME: NEW RENAL FAILURE</p> <p>Definition: Acute post-operative renal insufficiency resulting in two or more of the following: 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> <p>Data: Yes No</p>	<p>Field Name: NRF</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
239	<p>NAME: HAEMOFILTRATION</p> <p>Definition: Acute institution of haemofiltration for renal failure. Excludes haemofiltration for removal of fluid with normal serum urea and creatinine.</p> <p>Data: Yes No</p>	<p>Field Name: HAEMOFIL</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NRF = 1</p>

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
240	<p>NAME: HIGHEST POST-OP CREATININE LEVEL</p> <p>Definition: Highest Serum creatinine recorded after surgery.</p> <p>Data: $\geq 50 \mu\text{mol/L}$ to $\leq 2000 \mu\text{mol/L}$</p>	<p>Field Name: POSTCR</p> <p>Field Type: NUMERIC</p> <p>Format: NNNN</p> <p>Codes: As per adjacent data -1 = Unknown</p> <p>Constraints: Compulsory field</p>
241	<p>NAME: PERI-OPERATIVE AMI</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, provided operation does not involve myocardial incision.</p> <p>b. New wall motion abnormalities</p> <p>c. Serial EGG (at least two) showing new Q waves, duration $\geq 0.03\text{ms}$ in 2 contiguous leads.</p> <p>Data: Yes No</p>	<p>Field Name: POMI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
242	<p>NAME: PERI-OPERATIVE CARDIOGENIC SHOCK</p> <p>Definition: Clinical criteria for cardiogenic shock are:</p> <p>a. Hypotension (a systolic blood pressure < 90 mmHg &/or OR CI < 2.0 for at least 30 minutes</p> <p>b. or the need for supportive measures to maintain a systolic pressure $>$ or $= 90$ mmHg or a CI > 2.0</p> <p>Data: Yes No</p>	<p>Field Name: POCS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Compulsory field</p>
243	<p>NAME: CARDIAC INOTROPE USE – FOR LONGER THAN 4 HOURS POST-OPERATIVELY</p> <p>Definition: Any inotrope use for longer than 4 hours post-operatively. (Includes Dopamine at $> 300 \mu\text{g}/\text{min}$)</p> <p>Data: Yes No</p>	<p>Field Name: CIUSE</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
244	<p>NAME: CARDIAC INOTROPE USE – FOR LOW CARDIAC OUTPUT SYNDROME</p> <p>Definition: Inotrope use for Low Cardiac Output Syndrome: when an inotrope is administered with the intent to improve cardiac output, irrespective of the reasons for that decision.</p> <p>Data: Yes No</p>	<p>Field Name: IULowOut</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
245	<p>NAME: CARDIAC INOTROPE USE – FOR LOW SVR SYNDROME</p> <p>Definition: Inotrope use for Low Systemic Vascular Resistance Syndrome: when a primarily alpha adrenergic agonist is given with the intent to increase SVR if SVR < 800. This is usually in presence of high cardiac output. Does not include Noradrenalin given with Milrinone.</p> <p>Data: Yes No</p>	<p>Field Name: IULowSVR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
246	<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>	<p>Field Name: NARRT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
247	<p>NAME: NEW HEART BLOCK (REQUIRING PPM)</p> <p>Definition: New heart block requiring the implantation of a permanent pacemaker prior to discharge.</p> <p>Data: Yes No</p>	<p>Field Name: HB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NARRT = 1</p>
248	<p>NAME: NEW OTHER BRADY-ARRHYTHMIA (REQUIRING PPM)</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>Field Name: BA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NARRT = 1</p>

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
249	<p>NAME: CARDIAC ARREST</p> <p>Definition: A new cardiac arrest documented by one of the following:</p> <p style="margin-left: 20px;">a. ventricular fibrillation b. rapid ventricular tachycardia with haemodynamic instability c. asystole.</p> <p>Data: Yes No</p>	<p>Field Name: CA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NARRT = 1</p>
250	<p>NAME: NEW ATRIAL ARRHYTHMIA (REQUIRING RX) ATRIAL FIBRILLATION OR FLUTTER</p> <p>Definition: New onset of atrial fibrillation/flutter (AF) requiring treatment. Does not include recurrence of AF, which was present pre-operatively.</p> <p>Data: Yes No</p>	<p>Field Name: AFIB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NARRT = 1</p>
251	<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>Field Name: NARRTV</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if NARRT = 1</p>
252	<p>NAME: STROKE PERMANENT</p> <p>Definition: A new central neurologic deficit persisting for > 72 hours.</p> <p>Data: Yes No</p>	<p>Field Name: CVA_P</p> <p>Field Type: NUMERIC</p> <p>Format: 1</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
253	<p>NAME: STROKE TRANSIENT</p> <p>Definition: A new transient central neurologic deficit that resolves completely within 72 hours (TIA, RIND).</p> <p>Data: Yes No</p>	<p>Field Name: CVA_T</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
254	<p>NAME: NEW CONTINUOUS COMA ≥24 HOURS</p> <p>Definition: New post-operative coma that persists for at least 24 hours in a non-sedated patient</p> <p>Data: Yes No</p>	<p>Field Name: COMA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
255	<p>NAME: PROLONGED VENTILATION > 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>	<p>Field Name: VENT_P</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
256	<p>NAME: PULMONARY EMBOLISM</p> <p>Definition: New Pulmonary Embolism diagnosed by study such as V/Q scan or angiogram.</p> <p>Data: Yes No</p>	<p>Field Name: PUEMB</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
257	<p>NAME: PNEUMONIA</p> <p>Definition: Pneumonia diagnosed by one of the following: positive cultures of sputum or trans-tracheal aspirate and consistent with clinical findings of pneumonia (should include radiological changes).</p> <p>Data: Yes No</p>	<p>Field Name: PUPNU</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
258	<p>NAME: RE-INTUBATION AND VENTILATION</p> <p>Definition: Was re-intubation required for any reason during hospitalisation?</p> <p>Data: Yes No</p>	<p>Field Name: PURINT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 11. Post-Operative Data

Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
259	<p>NAME: DEEP STERNAL WOUND INFECTION</p> <p>Definition: Involves muscle and bone, with or without mediastinal involvement, as demonstrated by surgical exploration. Must have: wound debridement and one of the following:</p> <p style="margin-left: 20px;">a. Positive culture b. Treatment with antibiotics</p> <p>Data: Yes No</p>	<p>Field Name: INFDS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
260	<p>NAME: DEEP THORACOTOMY WOUND INFECTION</p> <p>Definition: An infection involving a thoracotomy or parasternal site.</p> <p>Must have one of the following conditions:</p> <p style="margin-left: 20px;">a. Wound opened with excision of tissue b. Positive culture c. Treatment with antibiotics</p> <p>Data: Yes No</p>	<p>Field Name: INFTH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
261	<p>NAME: SEPTICAEMIA</p> <p>Definition: Septicaemia requires positive blood cultures supported by at least two of the following indices of clinical infection:</p> <p style="margin-left: 20px;">A. Fever B. Elevated granulocyte cell counts C. Elevated and increasing CRP D. Elevated and increasing ESR, post-operatively.</p> <p>Data: Yes No</p>	<p>Field Name: INFSP</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
262	<p>NAME: AORTIC DISSECTION</p> <p>Definition: Dissection occurring in any part of the aorta.</p> <p>Data: Yes No</p>	<p>Field Name: NAODS</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
263	<p>NAME: ACUTE LIMB ISCHAEMIA</p> <p>Definition: Any complication producing limb ischaemia?</p> <p>Data: None Upper limb Lower limb</p>	<p>Field Name: LISCH</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 0 = None 2 = Upper 3 = Lower -1 = Unknown</p> <p>Constraints: Compulsory field</p>

Section 11. Post-Operative Data
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Complications

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
264	<p>NAME: ANTICOAGULANT COMPLICATIONS</p> <p>Definition: Any bleeding, haemorrhage, and/or embolic events related to anticoagulant therapy?</p> <p>Data: Yes No</p>	<p>Field Name: ACOAG</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
265	<p>NAME: GIT COMPLICATIONS</p> <p>Definition: Post-operative occurrence of any GI complication including:</p> <p style="margin-left: 20px;">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. Hepatic f. Other GI complication.</p> <p>Data: Yes No</p>	<p>Field Name: GIT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
266	<p>NAME: MULTI -SYSTEM FAILURE</p> <p>Definition: Two or more of the following major organ systems to fail concurrently for at least 48 hours: Renal - New renal failure (defined previously); Respiratory - Requires endotracheal intubation for respiratory dysfunction; Cardiac - The use of inotropes and/or IABP to treat low cardiac output.</p> <p>Data: Yes No</p>	<p>Field Name: MSF</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>

Section 12: Mortality/Readmission

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
267	<p>NAME: DISCHARGE</p> <p>Definition: Patient was discharged from the hospital following the admission during which the surgery occurred.</p> <p>Data: Home = Discharged to home, with no planned contact before routine review. Hospital in the home = Discharged to home, with planned visits to home by medical or paramedical staff. Rehabilitation Unit/Hospital = Discharged for inpatient rehabilitation. Local or referring hospital = Discharged to hospital for continuing acute care. Hospital Mortality</p>	<p>Field Name: Dischar</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Home 2 = Hospital in the Home 3 = Rehabilitation Unit/Hospital 4 = Local or referring hospital 5 = Hospital Mortality</p> <p>Constraints: Compulsory field</p>
268	<p>NAME: MORTALITY POST-DISCHARGE</p> <p>Definition: Specify whether the patient died within 30 days of surgery after discharge from hospital.</p> <p>Data: Yes No</p>	<p>Field Name: MORTPD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if Dischar < 5</p>
269	<p>NAME: MORTALITY - DATE</p> <p>Definition: Provide date of death in hospital during the index admission at any time after the procedure, or death after discharge from hospital within thirty days of the procedure.</p> <p>Data: (Before system date)</p>	<p>Field Name: MORT_D</p> <p>Field Type: DATE</p> <p>Format: DD/MM/YYYY</p> <p>Codes:</p> <p>Constraints: Must not be Null if Dischar = 5 or MORTPD = 1</p>
270	<p>NAME: MORTALITY - LOCATION</p> <p>Definition: Specify the patient location at time of death:</p> <p>Data: Operating Room: (OR) Hospital in which operation performed: (Other than Operating Room) Home: (Including Hospital in the Home) Other Care Facility</p>	<p>Field Name: MORT_L</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = OR 2 = Hospital 3 = Home 4 = Other Facility</p> <p>Constraints: Must not be Null if Dischar = 5 or MORTPD = 1</p>

Section 12: Mortality/Readmission

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
271	<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 Respiratory Failure Multisystem failure Other Unknown Pulmonary Embolism Aortic Dissection</p>	<p>Field Name: MORT_R</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Cardiac 2 = Neurologic 3 = Renal 4 = Vascular 5 = Infection 6 = Respiratory failure 8 = Multisystem failure 9 = Other 10 = Unknown 11 = Pulmonary 12 = Aortic</p> <p>Constraints: Must not be Null if Dischar = 5 or MORTPD = 1</p>
272	<p>NAME: MORTALITY - SUBSEQUENT CAUSE</p> <p>Definition: Specify SUBSEQUENT cause of death. This applies only when PRIMARY cause of death is cardiac or infection.</p> <p>Data: If PRIMARY cause is cardiac Ischaemia Other</p> <p style="padding-left: 2em;">If PRIMARY cause is infection Septicaemia Endocarditis Other</p>	<p>Field Name: MORT_SR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Ischemia 2 = Other 3 = Septicaemia 4 = Endocarditis 5 = Other</p> <p style="padding-left: 2em;">-1 = Unknown</p> <p>Constraints: Must not be Null if MORT_R = 1 or 5</p>

Section 12: Mortality/Readmission

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
273	<p>NAME: COGNISANT PATIENT WITHDRAWS FROM TREATMENT</p> <p>Definition: Patient who was aware of the consequences to his/her actions, elected to withdraw treatment in circumstances where they would survive if treatment was continued. NOTE: Completing "YES" to this field implies automatic review of patient's hospital file and permission for ASCTS personnel to review their case.</p> <p>Data: Yes No</p>	<p>Field Name: WITHDRAW</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints:</p>
274	<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. (‘readmission’ means admission to general hospital not emergency, short-stay wards or planned transfer to rehabilitation facility)</p> <p>Data: (Date of surgery counts as day 0) Yes No</p>	<p>Field Name: READ</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Compulsory field</p>
275	<p>NAME: READMIT REASON - ANTICOAGULANT COMPLICATION</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Anticoagulant Complication.</p> <p>Data: Yes No</p>	<p>Field Name: READAC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
276	<p>NAME: READMIT REASON - ARRHYTHMIA</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Arrhythmia.</p> <p>Data: Yes No</p>	<p>Field Name: READAR</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>

Section 12: Mortality/Readmission

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
277	<p>NAME: READMIT REASON - CONGESTIVE HEART FAILURE (CHF)</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Congestive Heart Failure (CHF), by one of the following:</p> <p style="margin-left: 20px;">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> <p>Data: Yes No</p>	<p>Field Name: READCHF</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
278	<p>NAME: READMIT REASON - VALVE DYSFUNCTION</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Valve Dysfunction.</p> <p>Data: Yes No</p>	<p>Field Name: READVD</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
279	<p>NAME: READMIT REASON - PERICARDIAL EFFUSION</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Pericardial Effusion.</p> <p>Data: Yes No</p>	<p>Field Name: READPE</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
280	<p>NAME: READMIT REASON - CARDIAC TAMPONADE</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Cardiac Tamponade.</p> <p>Data: Yes No</p>	<p>Field Name: READCT</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if READ = 1</p>

Section 12: Mortality/Readmission

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
281	<p>NAME: READMIT REASON - OTHER COMPLICATION RELATED TO CARDIAC SURGERY</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Other Complication related to Cardiac Surgery (eg. renal, hepatic, GI, etc.).</p> <p>Data: Yes No</p>	<p>Field Name: READOTHC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
282	<p>NAME: READMIT REASON - DEEP STERNAL INFECTION</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Deep Sternal Infection; Involves muscle and bone, with or without mediastinal involvement, as demonstrated by surgical exploration. Must have: wound debridement and one of the following:</p> <p style="margin-left: 20px;">a. Positive culture b. Treatment with antibiotics</p> <p>Data: Yes No</p>	<p>Field Name: READDSI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
283	<p>NAME: READMIT REASON - INCISIONAL COMPLICATION</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Other Incisional Complication.</p> <p>Data: Yes No</p>	<p>Field Name: READIC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
284	<p>NAME: READMIT REASON - PNEUMONIA OR OTHER RESPIRATORY COMPLICATION</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Pneumonia or other Respiratory Complication, diagnosed by one of the following: positive cultures of sputum or trans-tracheal aspirate and consistent with clinical findings of pneumonia (should include radiological changes).</p> <p>Data: Yes No</p>	<p>Field Name: READRC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>

Section 12: Mortality/Readmission

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
285	<p>NAME: READMIT REASON - MYOCARDIAL INFARCTION (MI)</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Myocardial Infarction (MI), diagnosed by finding at least two of the following three criteria:</p> <p style="padding-left: 40px;">Same as pre-op AMI (page 10-11)</p> <p>Data: Yes No</p>	<p>Field Name: READMI</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No -1 = Unknown</p> <p>Constraints: Must not be Null if READ = 1</p>
286	<p>NAME: READMIT REASON - RECURRENT ANGINA</p> <p>Definition: Reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Recurrent Angina. Objective confirmation that chest pain is due to ischaemia by exercise test (nuclear, echo, treadmill or angiography).</p> <p>Data: Yes No</p>	<p>Field Name: READRA</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>
287	<p>NAME: READMIT REASON - READMISSION UNRELATED TO CARDIAC SURGERY</p> <p>Definition: Primary reason the patient was readmitted as an in-patient within 30 days from the date of surgery was Other readmission unrelated to Cardiac Surgery.</p> <p>Data: Yes No</p>	<p>Field Name: READOTHNC</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints: Must not be Null if READ = 1</p>

Automatic Data (not entered on the Data Collection Form)

#	FUNCTIONAL DEFINITIONS	DATABASE DEFINITIONS
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	<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. Generated by the system this must be blank for data transferring.</p> <p>Data: (Unique arbitrary permanent value for each patient)</p>	<p>Field Name: PatientID</p> <p>Field Type:</p> <p>Format:</p> <p>Codes:</p> <p>Constraints:</p>
	<p>NAME: ADMISSION 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 admission. Once assigned to an admission, this can never be changed or reused. Generated by the system this must be blank for data transferring.</p> <p>Data: (Unique arbitrary permanent value for each admission)</p>	<p>Field Name: AdmissionID</p> <p>Field Type:</p> <p>Format:</p> <p>Codes:</p> <p>Constraints:</p>
	<p>NAME: OPERATION 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 operation. Once assigned to an operation, this can never be changed or reused. Generated by the system this must be blank for data transferring.</p> <p>Data: (Unique arbitrary permanent value for each admission)</p>	<p>Field Name: OperationID</p> <p>Field Type:</p> <p>Format:</p> <p>Codes:</p> <p>Constraints:</p>
	<p>NAME: AGE</p> <p>Definition: Age of the patient at surgery.</p> <p>Data: (calculated from DOP-DOB)</p>	<p>Field Name: AGE</p> <p>Field Type: NUMERIC</p> <p>Format: NN</p> <p>Codes:</p> <p>Constraints:</p>
	<p>NAME: BMI</p> <p>Definition: Body Mass Index calculated by the following equation. $WKG / (HTM/100)^2$ Calculated automatically where height and weight is available.</p> <p>Data: kg/m²</p>	<p>Field Name: BMI</p> <p>Field Type: NUMERIC</p> <p>Format: NN.N</p> <p>Codes:</p> <p>Constraints:</p>
	<p>NAME: BSA</p> <p>Definition: Body Surface area calculated by the following equation. $(0.007184 \times HTM^{0.725} \times WKG^{0.425})$ Calculated automatically where height and weight is available.</p> <p>Data: m²</p>	<p>Field Name: BSA</p> <p>Field Type: NUMERIC</p> <p>Format: N.NN</p> <p>Codes:</p> <p>Constraints:</p>

Automatic Data (not entered on the Data Collection Form)

FUNCTIONAL DEFINITIONS DATABASE DEFINITIONS

	<p>NAME: Number of hours in ICU (INITIAL STAY ONLY)</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). Round to the nearest hour eg 6 hours 25 minutes is rounded down to 6 hours, and 6 hours 35 minutes is rounded up to 7 hours. In the unlikely event that the time is exactly 30 minutes between the hour then round up.</p> <p>Data: (calculated)</p>	<p>Field Name: ICU</p> <p>Field Type: NUMERIC</p> <p>Format: NNNN</p> <p>Codes:</p> <p>Constraints:</p>
	<p>NAME: MORTALITY WITHIN 30 DAYS OF SURGERY</p> <p>Definition: Specify whether the patient died within 30 days after the procedure was performed. (Date of surgery counts as day 0; calculated from MORT_D-DOP)</p> <p>Data: Yes No</p>	<p>Field Name: MORT30</p> <p>Field Type: NUMERIC</p> <p>Format: N</p> <p>Codes: 1 = Yes 0 = No</p> <p>Constraints:</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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: AOIM_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: AOEX_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: MIIM_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</p>

Automatic Data (not entered on the Data Collection Form)

FUNCTIONAL DEFINITIONS DATABASE DEFINITIONS

	<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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: MIEX_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: TRIM_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</p>
	<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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: TREX_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: PUIM_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</p>
	<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 A: Autograft H: Homograft/Allograft R: Ring/Band</p>	<p>Field Name: PUEX_T</p> <p>Field Type: TEXT</p> <p>Format: Alphanumeric</p> <p>Codes: As per data adjacent</p> <p>Constraints:</p>

Database Inclusion Criteria

ASCTS require data on the following patients:

All patients undergoing (i) cardiac surgery, (ii) other thoracic surgery using cardiopulmonary bypass, or (iii) pericardiectomy for constrictive pericarditis, where performed on or off Cardiopulmonary Bypass.

Form Completion:

One form must be completed for each procedure as defined above. Procedures such as sternal wound debridement are not cardiac surgery and therefore would not require a second form to be completed.

Therefore, a patient who undergoes two procedures (as defined above) in the same admission will appear on two separate forms.

If the second procedure is a result of complications from the first procedure then the first form will include the second procedure as a “Return to Theatre” under post-operative data.

The second form will include the previous procedure under Section 4 – Previous Intervention.

Both forms will require all sections to be completed.

On the first form the Post-operative Complications section will be completed at the time of the second procedure (i.e. will include all complications that occur in between the first and second procedures. On the second form complications which are present between the time of the second procedure and discharge will be entered.

Mortality/Readmission data must be completed on both forms. We will sort out the implications of “dying twice” in the database by searching for matching UR numbers etc.

Data Collection Form

Instructions for Completion

GENERAL DESCRIPTION

The following pages show the ASCTS Data Collection Form. This form contains only the ASCTS Minimum Dataset. Individual Hospitals may have a slightly different form depending on the type and amount of additional data each Hospital wishes to collect.

The ASCTS Data collection form consists of 3 parts: Pre operative, Intra Operative and Post Operative.

Pre Operative:

We recommend that this section of the form should be completed by the **Resident**. This part of the form contains information on the patient's demographics, risk factors, pre operative cardiac status and previous interventions.

Intra Operative:

We recommend that this section of the form should be completed by the **Surgeon**. This part of the form contains information on the patient's haemodynamic data, operative status, and information directly related to the procedure performed.

Post Operative:

We recommend that this section of the form should be completed by the **Registrar**. This part of the form contains information on post-operative complications and mortality

We also recommend that the **Data Manager** check all parts of the form for completeness and make any amendment as required.

Each part is contained on separate pages from the other parts. They can therefore be separated from each other for the purposes of data collection if required.

SUBMISSION OF DATA TO THE ASCTS PROJECT

When all 3 parts of the form have been completed and checked this should be indicated on the top of the first page.