Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, July 14, 2014

Attendees: P=Present; A=Absent; X=Expected Absence

Active PIs		**In Progress PIs Continued**	
P	Michael Avidan, MD - Wash U	**A**	Brian Bateman, MD - MGH
P	Michael Aziz, MD - OHSU	**A**	Matthias Eikermann, MD - MGH
A	Mitchell Berman, MD - Columbia	**A**	Bassam Kadry, MD - Stanford
P	Daniel Biggs, MD – Oklahoma	A	Fabian Kooij, MD – AMC Amsterdam
A	Randal Blank, MD - Virginia	**P**	Warren Levy, MD – Pennsylvania
P	Robert Craft, MD –Tennessee	**A**	Philip Lirk, MD – AMC Amsterdam
A	Douglas Colquhoun, MD –Virginia	**A**	Marco Navetta, MD – Santa Barbara Cottage
A	Jurgen de Graaff MD – Utrecht	**A**	David Robinowitz, MD - UCSF
A	Karen Domino, MD, MPH – U of Washington	**P**	Leif Saager, MD – Cleveland Clinic
A	Marcel Durieux, MD, PhD- Virginia	**A**	Robert Schonberger, MD - Yale
P	Jerry Epps, MD - Tennessee	**A**	Scott Springman, MD – Wisconsin
P	Jesse Ehrenfeld, MD - Vanderbilt		
A	Ana Fernandez-Bustamente, MD - Colorado	**Chairs**	
P	Peter Fleishut, MD – Weill-Cornell	**A**	David C. Adams, MD - Vermont
A	Alexander Friend, MD –Vermont	**P**	Jerry Epps, MD – Tennessee
A	Daniel Helsten, MD – Wash U	**P**	Timothy Morey, MD - Florida
P	Leslie Jameson, MD - Colorado	**P**	Kevin Tremper, PhD, MD - Michigan
P	Sachin Kheterpal, MD - Michigan	**A**	Warren Sandberg, MD, PhD – Vanderbilt
P	Bhiken Naik, MD - Virginia	**A**	Wilton van Klei, MD – Utrecht
P	Bala Nair, PhD – U of Washington	**MPOG**	
P	Nathan Pace, MD – Utah	**A**	Mark Dehring
P	William Paganelli, MD – Vermont	**P**	Genevieve Bell
P	W. Pasma - Utrecht	**P**	Tory Lacca, MBA
A	Kelley Smith, MD – Utah	**P**	Nirav Shah, MD
A	Wilton van Klei, MD – Utrecht	**P**	Amy Shanks, MS, PhDc
A	Jonathan Wanderer, MD - Vanderbilt	**P**	Tyler Tremper
A	Kevin Wethington, MD - Utah	**P**	John Vandervest

Others – Invited

P	Mark Fung, MD - Vermont	A	Timothy McMurry, PhD – Virginia
A	Andreas Hoeft, MD – Bonn Germany	A	Karen Nanji, MD – MGH
A	Sandra Holtzclaw - Vanderbilt	A	Peter Schulman, MD - OHSU
A	Thomas Jeffries, MD – Trinity Health		

Ground Rules for PCRC:

1. Each protocol must have specific testable hypothesis with data available in MPOG data structure
2. People requesting specific data elements must also supply that data type to MPOG. If you don't submit that data type currently, then you can't get that type of data type out. However, if you have a co-investigator from another site that does supply that data, then you can ask for that

type of data. The reason is so someone on the research team understands the limitations of each data element being requested and used

3. To ensure that there is not a lack of clarity about what the status of the proposal is, each proposal will get the following overall decision at the end of each presentation and discussion
    a. Accept with minimal or no changes required
        i. E-mail revision to PCRC
    b. Accept with moderate changes required
        i. Represent at a future PCRC
        ii. E-mail Revisions to PCRC
    c. Revise and reconsider at future meeting
    d. Reject
4. Meeting will be recorded to be shared later with members of MPOG via the MPOG website. There were no objections to this via the members that were on the call.

Presentation

Title: Understanding Intra Operative Blood Use: a retrospective procedure-specific analysis of MPOG data

Proposed Authors: Mark Fung, MD PhD.William Paganelli, MD PhD, Jordan Taylor, MS, Ian Black, MD, Peter Callas, PhD, Jill Warrington, MD PhD, Sachin Kheterpal, MD MBA
Primary Institution: University of Vermont

Presented by: Mark Fung, MD

Discussion Points:

- Trauma patients are currently excluded, does this include the burn debridement cases that subsequently follow since they routinely receive a lot of blood?
  Answer: Yes those will also be excluded
- Autologous blood can be separated out. Will that be done?
  Answer: Yes that can be looked at but the overall goal is for the total about of RBC. Therefore, it will be combined
- For the patient risk factors to be investigated, there are no preoperative medications listed. Have you thought of this approach?
  Answer: Yes Dr. Fung has considered this but was not sure on the quality of data that would be available. In the future, this might be the next step to investigate but not currently a goal for this project.
- Currently the protocol excludes cases that are deemed low risk for blood transfusions. This may be a good opportunity to demonstrate and provide supporting evidence to our surgical colleagues that a T&S isn't necessary
  Answer: Dr. Fung agrees and feels that this feedback is important to minimize unnecessary T&S.

- The cardiac surgery literature has demonstrated baseline platelet counts as a predictor of transfusions. Will this be investigated with this project?
  Answer: Yes this will be included and was an over-sight not to be included
- There is a potential bias to under-estimate the amount of transfusions because patients may get transfused after they left the OR
  Answer: Dr. Fung agrees this a correct statement and the bias will be noted in the manuscript.
- For full disclosure, there is another project that is PCRC approved and being presented at ASA this year looking at the macroscopic level of blood transfusions overall and also separated by cardiac and non-cardiac patients. This is not a case-by-case analysis.
  Question for PCRC members: Are you comfortable with both projects being different enough?
  Answer: Overall no members saw a conflict
- Sachin recommended removing all cases with an ASAE
  Answer: Dr. Fung would like to keep these cases included but set aside for a sub-analysis to allow blood banks members information on the amount of blood needed for emergent cases. Sachin agreed this is would be useful.
- Is Dr. Fung interested in intraoperative predictors as well? The literature has shown that intraoperative risk of bleeding has been associated with temperature and blood pressure.

Answer: At this point no intraoperative characteristics will be examined. This study will focus on the information we know about the patients before they get to the OR. This project will focus on preoperative only but future projects may focus on intraoperative as well.

- We currently have Anes based CPT codes which takes surgical CPT codes and collapses them down. Are anes based CPT codes the right way to go for classifying the cases for this study? Will too much granularity be lost? Currently in the MPOG database we have more sites contributing anes CPT codes than surgical CPT codes. This is to avoid having to code cases via manual classification.

Answer: The consensus of the PCRC members was to move forward with the lower granularity and use the anes CPT codes

- Dr. Pace recommends using quantile regression. He will communicate off-line with Dr. Fung to determine if this is a reasonable option and the decision will be determined in the final protocol circulated for approval.

Institution	**Vote**
Columbia	**Not on Call**
Oregon Health Science University	**Accept with Minor Revisions**
University Medical Center of Utrecht	**Accept with Minor Revisions**
University of Colorado	**Accept with Minor Revisions**
University of Florida	**Accept with Minor Revisions**
University of Michigan	**Accept with Minor Revisions**
University of Oklahoma	**Accept with Minor Revisions**

University of Tennessee	**Accept with Minor Revisions**
University of Utah	**Accept with Minor Revisions**
University of Vermont	**Presenting Institution**
University of Virginia	**Accept with Minor Revisions**
University of Washington	**Accept with Minor Revisions**
Vanderbilt	**Accept with Minor Revisions**
Washington University , St. Louis	**Accept with Minor Revisions**
Weill-Cornell Medical Center – New York Presbyterian	**Not on call**

Final Decision: Accept with Minor Revisions