Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, September 11, 2017

Attendance:

Arbi 'Ben' Abdallah (Washington University)	Michael Mathis (Michigan)
Michael Avidan (Washington University)	Patrick McCormick (Memorial Sloan Kettering)
Michael Aziz (Oregon)	Anna Nachamie (Weill Cornell)
Joshua Berris (Beaumont)	Masakatsu Nanamori (Henry Ford)
Dan Biggs (Oklahoma)	Bhiken Naik (Virginia)
Ruth Cassidy (Michigan)	Nathan Pace (Utah)
Andrew Chang (Michigan)	William Paganelli (Vermont)
Douglas Colquhoun (Michigan)	William Peterson (Sparrow)
Robert Craft (Tennessee)	Leif Saager (Michigan)
Germaine Cuff (NYU Langone)	Tara Semenkovich (Washington University)
Leslie Jameson (Colorado)	Nirav Shah (Michigan)
Shelley Housey (Michigan)	Amy Shanks (Michigan)
Sachin Kheterpal (Michigan)	Allie Thompson (Michigan)
Kai Kuck (Utah)	Kevin Tremper (Michigan)
Tory Lacca (Michigan)	John Vandervest (Michigan)
Kamal Maheshwari (Cleveland Clinic)	

Announcements:

- Twitter account: @MPOGASPIRE
- MPOG/ASPIRE Retreat – October 20, 2017
    - Agenda available on the website
    - Please register if you are planning to attend
- Enhanced Observational Study (EOS) Updates
    - First sites started data collection last week (2-week data collection)
    - 13 participating sites in total
- Presentations today reflect a valuable collaboration between MPOG-STS data integration

PCRC 0042 - "Intraoperative Management Strategies in Patients Undergoing Esophagectomy: A Combined Report from the Multicenter Perioperative Outcomes Group and the Society of Thoracic Surgeons"

Principle Investigator: Mark Willingham, MD, MSCI
Institution: Washington University

Discussion/Questions

- Comment: First project to leverage this data integration (MPOG-STS) is a large descriptive project. Next projects could include examining outcomes data and then a possible intervention project.
- Comment: Discussion points
    - Approach to statistical analysis (latent class analysis)
        - Q: What are the manifest variables (these are usually categorical)?
            - A: We may need to categorize our continuous variables into a propensity to use epidurals, fluids, etc.
        - Q: What are the latent classes?
            - A: Latent classes are defined by variables listed in Table 3 to determine whether the treatment pattern is homogenous or clustered?
            - A: Looking for patterns across items listed in Table 3 – threshold value for inclusion.
            - A: Latent class variables define the treatment patterns.
    - Clinical considerations regarding proposed analytic plan
        - Comment: Approach is great – latent classes allows for capturing/integrating various components of anesthetic management into different classes that can be built upon for the outcomes portion of the project
        - Q: Any variables or considerations missing from tables?
            - A: No, variables currently included will reflect variation in practice patterns.
        - Q: How reliably is surgical approach documented? Should this be included as stratification variable?
            - A: Within MPOG, surgical approach may only be included in planned procedure text.
            - A: Will be excluded for descriptive portion of the study, but will be included for outcomes portion since this information is documented in STS.
        - Comment: Without categorizing surgical technique, practice pattern may not make as much sense, even for the descriptive project. Practice patterns influenced by surgical technique.
            - Q: How often does the scheduled procedure text reflect actual procedure?
                - A: Anonymized institution variable will be included
                - A: Analysis of procedure text to infer what the planned technique was
                - A: Stratify by 4 main pre-planned techniques for this type of surgery
    - Table 1 structure
        - Q: Should you separate out crystalloids and colloids?
            - A: Yes, seems reasonable to do.
        - Q: What is the MLAC?

- A: Tried to develop a method for measuring total epidural dose based on OB literature.
- A: Alternative to continuous variable would be categorical for (Y/N) epidural used. Or was the epidural placed and/or was epidural run during the majority of the case (Y/N).
    - Comment: Interesting aspect of these cases are how people use epidurals.
    - Comment: Statistical approaches on how to incorporate total fluids.

FINAL DECISION: Electronic revisions

Institution	Vote
Academic Medical Center (AMC) Amsterdam	**N/A**
Beaumont	**Accept**
Bronson	**N/A**
Cleveland Clinic	**N/A**
Columbia	**N/A**
Henry Ford	**N/A**
Holland	**N/A**
Memorial Sloan Kettering	**Electronic**
NY Langone	**Accept**
Oregon Health Science University	**Electronic**
St. Joseph/Trinity	**N/A**
Sparrow	**N/A**
Stanford	**N/A**
University Medical Center of Utrecht	**N/A**
University of Colorado	**Electronic revisions**
University of Michigan	**Electronic revisions**
University of Oklahoma	**N/A**
University of Pennsylvania	**N/A**
University of Tennessee	**Electronic revisions**
University of Utah	**Revise and represent**
University of Vermont	**Electronic revisions**
University of Virginia	**Electronic revisions**
University of Washington	**N/A**
Vanderbilt	**N/A**
Wake Forest	**N/A**
Washington University, St. Louis	**Abstain**
Weill-Cornell Medical Center – New York Presbyterian	**N/A**
Yale	**N/A**

PCRC 0043 - "Mediastinal mass and anesthesia – risk factors, avoidance, incidence, and treatment of mediastinal mass syndrome in patients undergoing general anesthesia"

Principle Investigator: Douglas Colquhoun MB ChB, MSc, MPH
Institution: University of Michigan

Discussion/Questions

- Q: Is there currently a classification system for patients undergoing this procedure based on symptomology?
    - A: Based on case reports/reviews, there are groupings of "safe" vs. "non-safe" patients.
- Q: How is STS database going to be used?
    - A: We need the STS preoperative diagnosis for defining inclusion population. Also, the secondary outcomes are coming from STS dataset.
- Q: What does this group think about how we are defining respiratory/cardiovascular compromise?
    - A: These are composite outcomes – gives equal weighting to outcomes that may not be the same severity.
    - A: Will acknowledge as a limitation.
- Q: Table 1 – recorded physiologic parameters should be reworded to variables.
    - A: Yes, we will revise the protocol.
- Comment: May want to include patient positioning as a structured variable.

FINAL DECISION: Electronic Revisions

Institution	Vote
Academic Medical Center (AMC) Amsterdam	**N/A**
Beaumont	**N/A**
Bronson	**N/A**
Cleveland Clinic	**N/A**
Columbia	**N/A**
Henry Ford	**N/A**
Holland	**N/A**
Memorial Sloan Kettering	**Accept**
NY Langone	**Accept**
Oregon Health Science University	**N/A**
St. Joseph/Trinity	**N/A**
Sparrow	**N/A**
Stanford	**N/A**
University Medical Center of Utrecht	**N/A**
University of Colorado	**N/A**
University of Michigan	**Abstain**
University of Oklahoma	**N/A**
University of Pennsylvania	**N/A**
University of Tennessee	**Accept**
University of Utah	**Electronic Revisions**
University of Vermont	**Electronic Revisions**
University of Virginia	**Electronic Revisions**
University of Washington	**N/A**
Vanderbilt	**N/A**
Wake Forest	**N/A**
Washington University, St. Louis	**Electronic Revisions**
Weill-Cornell Medical Center – New York Presbyterian	**N/A**
Yale	**N/A**