Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, September 14, 2015

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

	Michael Avidan, MD - Wash U	**p**	Bassam Kadry, MD - Stanford
p	Michael Aziz, MD - OHSU	**p**	Sachin Kheterpal, MD - Michigan
p	Brian Bateman, MD - MGH	**p**	Kai Kuck, MD - Utah
	Genevieve Bell – U Michigan (MPOG)	**x**	Tory Lacca, MBA – U Michigan (MPOG)
	Mitchell Berman, MD - Columbia	**p**	Michael Mathis, MD – U Michigan
p	Daniel Biggs, MD – Oklahoma	**P**	Bala Nair, PhD – U of Washington
	Randal Blank, MD - Virginia	**p**	Nathan Pace, MD – Utah
p	Robert Craft, MD –Tennessee	**p**	William Paganelli, MD – Vermont
p	Douglas Colquhoun, MD –Virginia		W. Pasma - Utrecht
P	Germaine Cuff, MD – NYU Langone		Leif Saager, MD – Cleveland Clinic
p	Jurgen de Graaff MD – Utrecht		Robert Schonberger, MD - Yale
	Karen Domino, MD, MPH – U of Washington	**p**	Nirav Shah, MD – U Michigan
	Marcel Durieux, MD, PhD- Virginia	**p**	Amy Shanks, PhD – U Michigan (MPOG)
	Jesse Ehrenfeld, MD - Vanderbilt		Roy Soto, MD - Beaumont
p	Ana Fernandez-Bustamente, MD - Colorado		Scott Springman, MD – U of Wisconsin
	Peter Fleishut, MD – Weill-Cornell	**p**	Kevin Tremper, PhD, MD – U of Michigan
	Alexander Friend, MD –Vermont		Zachary Turnbill, MD – Weill-Cornell
p	Greg Giambrone, MS – Weill Cornell		Wilton van Klei, MD – Utrecht
	Michael Godbold, MD – U Tennessee		John Vandervest – U Michigan
p	Daniel Helsten, MD – Wash U	**p**	Jonathan Wanderer, MD - Vanderbilt
p	Shelley Housey, MPH – U Michigan (MPOG)		Kevin Wethington, MD - Utah
P	Leslie Jameson, MD - Colorado		

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.

Updates

- Membership updates: First set of private hospitals from state of Michigan that received sponsorship from BCBS contributing data as of last week. 4 hospitals across 2 health systems
    - 8 hospitals will be contributing by the end of this week
- Good progress with EPIC roll-out
- Research update: Manuscript on intraoperative vent management published ahead of print in A&A
- Research update: Positive review with revised and reconsider on rescue of failed DL
- Research update: Several abstracts are accepted and turning into manuscripts to be submitted shortly
- MPOG Annual Retreat: Friday Oct 23. Everyone is welcome. Please go to the MPOG website and register. $100 registration fee that covers the cost of food

Proposal

The Risk of Epidural Hematoma After Neuraxial Anesthesia in Thrombocytopenic Obstetric Patients: A Report from the Multicenter Perioperative Outcomes Group Research Consortium

Linden Lee MD, Brian Bateman MD, Sachin Kheterpal MD, Michelle Housey MPH, Melissa E Bauer, D.O.

Comments

- CPT data is helpful to identifying c-sections or labor epidurals. For the vast majority of sites, we will be able to use CPT codes. Those that do not have CPT data submitted, we propose a mix method to use specific words to text search for. Is this ok to use a mix strategy? We recommend this as it will double our numbers. We will look at any case within 6 weeks of delivery. For those with CPT codes, we will be able to identify why they had another operation. For those that do not have CPT codes, we will do text based mapping for why she didn't another operation
    - If you do not have CPT codes, please send the text that you use to describe labor epidural to Shelley Housey
- Known limitation – Only laminectomies performed at their hospital. If they went to another hospital we will not see that
- Have approximately 90% coverage on pre-op meds. Anyone who did have a laminectomy, each site will go into their EHR to determine what happened and then we will determine if they had pre-disposing factors
- 66,000 women within 72 hours that have platelet values. Only 2% were thrombocytopenic. Only 1,000 patients with platelet < 100.

- Using Hanley's rule – 3/n – when you have a zero event rate figuring out the event rate is very tough. This is a known limitation because we have a small sample size
- What is the target journal? Sachin recommends Anesthesiology
- There are other exact methods besides Hanley's rule. Dr. Pace will email them to Shelley (mhousey@med.umich.edu)
- Why not look for ICD-9 codes of post-op epidural hematoma? If we have access to ICD-9 codes within their EHR then yes we will look to see if these are documented.
    - Will include ICD-9's in official search criteria
- Do you have a protocol at each site of when you do and do not place an epidural based on the platelet count? Each PI please send the protocol to Shelley Housey.
- Any concerns with primary outcome or search strategy?
    - None voiced
- Have preop diagnosis and medications for most patients. Sachin's bias is to still include these patients but that will be a limitation. Because any woman that did have the primary outcome will be hand-reviewed and therefore we will be able to determine her diagnosis and medications. Any objections? None voiced
- Does anyone remember bringing a woman to the OR for a decompressive laminectomy for epidural hematoma?
    - Utah had 1 within the last 6 weeks
    - UM had zero
- Any feedback on platelet stratification? Are we stratifying too carefully?
    - This may need to be center specific because of official guidelines. Would we collapse the guidelines of everyone below the guideline number? No recommendation off-hand but something that will need to be considered
- Would it be interesting to pull the charts of patients with some low platelet counts to do a review if the anesthesiologist knew what it was and if they discuss it?
    - It would be informative. But is the value with the effort?
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Institution	Vote
Academic Medical Center (AMC) Amsterdam	**Not present**
Cleveland Clinic	**Not present**
Columbia	**Not present**
Mercy Health System	**Accept – Minor revisions**
New York University	**Not Present**
Oregon Health Science University	**Accept – Minor revisions**
University Medical Center of Utrecht	**Accept – Minor revisions**
University of Colorado	**Accept – Minor revisions**
University of Florida	**Accept – Minor revisions**
University of Michigan	**Abstain**
University of Pennsylvania	**Not present**
University of Oklahoma	**Accept – Minor revisions**
University of Tennessee	**Accept – Minor revisions**
University of Utah	**Accept – Minor revisions**
University of Vermont	**Accept – Minor revisions**
University of Virginia	**Accept – Minor revisions**
University of Washington	**Accept – Minor revisions**
Vanderbilt	**Accept – Minor revisions**
Washington University , St. Louis	**Accept – Minor revisions**
Weill-Cornell Medical Center – New York Presbyterian	**Accept – Minor revisions**
Yale	**Not present**

Final Decision: Accept Minor Revisions