MSQC 2019 Data Collection Manual
Variables and Definitions

Hysterectomy Variables
Preop Variables
- Parity
- Prior Abdominopelvic Surgery Performed
- Indication for Procedure
- Preoperative Uterine Size

Intraop Variables
- Vaginal Prep
- Bleeding Barrier

Postop Variables
- Specimen Weight
Sources of information

• Operative report
  – Findings (CPT code, ICD-10 code)
  – Indication for procedure
  – Description of procedure (CPT code, surgical approach, bleeding barrier)

• Intraoperative record (vaginal prep, bleeding barrier)

• Pathology report
  – Diagnosis (CPT code, ICD-10 code)
  – Gross description (specimen weight)

• H&P (parity, prior surgeries, indications)

• Preoperative assessment (parity, prior surgeries, indications, preop uterine size)

• Imaging studies (preop uterine size)
Parity

- The number of children, greater than 20 weeks of gestation that a woman has given birth to
- important factor in determining surgical approach for hysterectomy.

Variable options:

1. Unknown
2. Known: if known, also enter *Parity Value* (between 0-30)
Prior AbdominoPelvic Surgery Performed

*Include:*

- Prior lower abdomen and pelvic procedures

*Exclude:*

- Procedures performed via hysteroscopy, vaginal, or perineal approach
- Prior upper abdominal procedures

Variable Options:

1. Abdominopelvic surgery not performed: No prior abdominopelvic surgery documented
2. C-section
3. Laparoscopic/robotic approach
4. Laparotomy/open approach: Excludes C-section
5. Approach not identified: Abdominopelvic surgery was performed, but approach not identified
Indication for Procedure

– The conditions/preoperative diagnoses listed by the surgeon as an indication for hysterectomy.

– For examples cervical or ovarian cancer, pelvic mass, pelvic organ prolapse or endometriosis.
Preoperative Uterine Size:

– The findings from the ultrasonography or surgeon reported uterine size closest to the hysterectomy
Intraop Variables

**Vaginal Prep**

Capture the primary vaginal antisepsis that was used to prepare the patient's vaginal mucosal surfaces prior to hysterectomy.

When both skin and mucous membranes are prepped, the prep applied to the mucous membrane is considered the vaginal prep.

When a specific prep is noted by nursing in the intraoperative record but a different prep is noted by the surgeon in the operative report, record the skin prep that is noted in the intraoperative record.
**Bleeding barrier**

- Description of hemostatic agents/sealants (e.g. Surgicel, gelfoam, etc.) or adhesive barrier applied in the Operative Report.
- To identify if these materials lead to higher rates of postoperative complications

Select Yes if one or more of the following were used during the hysterectomy:

<table>
<thead>
<tr>
<th>Bleeding Barrier Classification</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxidized Regenerated Cellulose</td>
<td>Surgicel®, Surgicel SNoW®, Surgicel® fibrillary</td>
</tr>
<tr>
<td></td>
<td><em>Products described as a “cellulose” hemostatic agent.</em></td>
</tr>
<tr>
<td>Thrombin and/or Fibrin Agents</td>
<td>Floseal®, Thrombi-Gel®, Tisseel®, Evicel®, Thrombin-JMI®, Evidthrom®, Recothrom®, Surgiflo®, TachoSil®</td>
</tr>
<tr>
<td></td>
<td><em>Products described as a “thrombin” or “fibrin” hemostatic agent.</em></td>
</tr>
<tr>
<td>Gelatin or Collagen Agents</td>
<td>Gelfoam®, Surgifoam®, Avitene®</td>
</tr>
<tr>
<td></td>
<td><em>Products described as a “gelatin” or “collagen” hemostatic agent</em></td>
</tr>
<tr>
<td>Microporous Polysaccharide Spheres</td>
<td>Arista®, Hemostase MPH®</td>
</tr>
<tr>
<td></td>
<td><em>Products described as a “microporous polysaccharide spheres” hemostatic agent</em></td>
</tr>
</tbody>
</table>
Specimen Weight

• to help determine the bulk and severity of disease, using weight as a marker.
• Report the uterine and adnexa/mass weight as documented within the pathology report.
• If the specimens are received by pathology separated, as in uterus separate from tubes and/or ovaries and/or mass and weighed separately, then add the weights together, select uterus + adnexa, and report the total weight.

1. Report ‘Specimen Weight”: select one
   - Grams
   - Gestation weeks
   - Unavailable: No documentation of a specimen weight is present within the medical record (either as ‘weight in grams’ or ‘weeks gestation’), then indicate “unavailable.”

2. Report the Value of above Specimen Weight: text in value

3. Report the Specimen Weight Type: select one
   - Uterine
   - Uterine + adnexa
HYSTERECTOMY TYPES BY SURGICAL APPROACH

Hysterectomies are classified according to the surgical approach used for the procedure. Surgical approach is distinguished by *route or method of surgical detachment* of the uterus from its surrounding supportive structures.

Here are some of the Hysterectomy *types* by *surgical approach*:

- Open
- Vaginal
- Laparoscopic
- Robotic Assisted Laparoscopic
- Laparoscopic Supracervical
- Robotic Supracervical
- Laparoscopic Assisted Vaginal
- Robotic Assisted Vaginal
Hysterectomy

- Total hysterectomy
- Hysterectomy plus bilateral salpingo-oophorectomy
- Subtotal hysterectomy
- Radical hysterectomy

- Right Adnex
- Left Adnex
- Right Parametrium
- Left Parametrium
- Body of uterus
- Cervix
- Vagina
- Fallopian tubes
- Ovary
- Nearby tissue (including Lymph Nodes)
Open Hysterectomy Often performed through a horizontal incision just within the pubic hairline. It can also be performed through a midline incision. The structures and supporting ligaments are detached by the surgeon through this incision.
**Vaginal Hysterectomy:** The procedure is completed through a circumferential incision around the cervix (frequently called the “colpotomy” in operative reports) and involves the removal of the cervix and uterine fundus. This type of hysterectomy is performed completely via a vaginal approach.

**POINTS TO CONSIDER:** If a diagnostic laparoscopy is performed and followed by a vaginal hysterectomy, the surgical approach is vaginal. If the ovaries and fallopian tubes are detached laparoscopically but the hysterectomy is performed vaginally, list the surgical approach as a vaginal hysterectomy.
Laparoscopic Supracervical Hysterectomy (LSH): This is the laparoscopic detachment of the uterine fundus down to the uterine arteries. The uterine fundus is then separated from the cervix, hemostasis of the cervical stump is achieved and the endocervical canal is coagulated. The uterine body is removed abdominally. The cervix is not removed.

Cervix is transected in order to free the uterine fundus for removal.
Robotic Supracervical Hysterectomy (RSH) is a procedure similar to a laparoscopic supracervical hysterectomy, except that the specialized laparoscopic instruments are connected to robotic arms, allowing the surgeon to have enhanced dexterity and visualization.

*Remember:* LSH/RSH is simply a laparoscopic hysterectomy where the cervix was left behind. Your operative report will describe a "cervical stump" or similar. Additionally, the pathology report, in the specimen section (listing of specimens) will not list a complete cervix. You may see where there is some cervical tissue, but the complete cervix should not be present. If it is, you may be dealing with a total hysterectomy instead.
Laparoscopic Hysterectomy: This is the laparoscopic ligament detachment of the uterine fundus and cervix. The uterus is often removed via the vagina, but alternatively, may be removed through the abdomen. Removal of the uterus may require bivalving, coring, or morcellating especially if the specimen is removed vaginally. The vaginal cuff may be closed either laparoscopically or vaginally.

Robotic Assisted Laparoscopic Hysterectomy (RALH) is a procedure similar to a laparoscopic hysterectomy, except that the specialized laparoscopic instruments are connected to robotic arms, allowing the surgeon to have enhanced dexterity and visualization.
Laparoscopic Assisted Vaginal Hysterectomy (LAVH) involves a combined laparoscopic and vaginal detachment of the uterine fundus and cervix from the ligamentous support. The uterine ligaments include:

- Round ligament
- Broad ligament
- Cardinal ligament (includes the uterine vessels which is commonly referred to in OP reports)
- Uterosacral ligament

*Route of specimen removal or closure of the vaginal cuff is NOT a determining factor for surgical approach.

Robotic Assisted Vaginal Hysterectomy (RAVH) is a procedure similar to a laparoscopic assisted vaginal hysterectomy, except that the specialized laparoscopic instruments are connected to robotic arms, allowing the surgeon to have enhanced dexterity and visualization.
LAVH vs. Laparoscopic Hysterectomy

- Route of specimen removal or closure of the vaginal cuff is NOT a determining factor when identifying if the hysterectomy is a LAVH or TLH. When differentiating between these surgical approaches, the SCQR must identify in the operative report how the uterine ligament detachment was performed.

Operative Report Clues:
- The wording of “cul-de-sac” may be a clue to look further for LAVH. This is the space on the anterior and posterior side of the uterus that is important for accessing and completing the detachment.
- When the colpotomy is performed an also be an indication to differentiate between laparoscopic hysterectomy and LAVH.
  - In a laparoscopic hysterectomy, the colpotomy is typically the last step and the uterus can be removed either through a port or through the vagina. A colpotomy ring is utilized to provide a firm surface for the cautery or blade to press against during the dissection through the vaginal wall tissue from the pneumoperitoneum/cavity.
  - In a LAVH, the colpotomy is performed prior to dissection of the Uterine Vessels and the Cardinal ligaments. This is necessary in order to “reach up” through the vagina into the retroperitoneal space to dissect the vessels and Cardinal/Uterosacral ligaments.
See **Hysterectomy Resources** within MSQC Program Manual for assistance with:

- Anatomy
- Determining Surgical Approach
- Assigning hysterectomy CPT codes

(Pages 219 to 224)