Australasian Pelvic Floor Procedure Data Dictionary

Version: 1.0

Date: 31 March 2023

Data Custodian

Monash University

Coordinating Principal Investigator

Professor Susannah Ahern

Contents

1. Registration Details

1.1. Patient Site Record ID

Description: This identifier is auto-generated and updated by the system which is combination of individual patient ID and Hopital/site ID.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Auto-generated

Data Source, Standard / Terminology / Code set in use:

N/A

1.2. Patient ID

Description: This identifier is auto-generated and updated by the system for each new patient in the system.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Auto-generated

Data Source, Standard / Terminology / Code set in use:

N/A

1.3. Date record created

Description: An auto generated date field, that records the date the Record ID was created. Can be used to analyse patient record numbers over time.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Auto-generated

Data Source, Standard / Terminology / Code set in use:

N/A

1.4. First Name

Description: The person's identifying name(s) within the family group or by which the person is socially identified, as represented by text.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 613340

1.5. Middle Name(s)

Description: The person's identifying name(s) within the family group or by which the person is socially identified, as represented by text.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 613340

1.6. Last Name

Description: The name a person has in common with some other members of their family, as represented by text. It is often hereditary, and is distinguished from that person's first given name.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 613331

1.7. Former Last Name

Description: The name a person has in common with some other members of their family, as represented by text. It is often hereditary, and is distinguished from that person's first given name.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 613332

1.8. Date of birth

Description: Patient's date of birth, expressed as DD-MM-YYYY

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 287007

1.9. Age at time of registration

Description: The person's age (completed) in years at time of registration.

Purpose: Consent

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 303794

1.10. Medicare number

Description: Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270101

1.11. Preferred language

Description: The language (including sign language) most preferred by the person for communication, as represented by a code

Purpose: Consent

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Bureau of Statistics 2016a. Australian Standard Classification of Languages (ASCL) 2016. ABS cat. no.1267.0. Canberra: https://www.abs.gov.au/statistics/classifications/australian-standard-classification-languages-ascl/latest-release
METEOR identifier: 659407

1.12. Is the patient of Aboriginal and/or Torres Strait Islander origin? *

Description: Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Adapted from Australian Institute of Health and Welfare (AIHW), https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/summary
METEOR identifier: 723676

***** *Will be included in database update*

1.13. Capacity to consent to the registry

Description: Patient's cognitive capicity to understand that their data is collection by the registry as represented by a code.

Purpose: Consent

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 338737

1.14. Street

Description: The name of the road applicable to the address site or complex, as represented by text where the patient normally resides, including house number (if applicable)

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 429747

1.15. Suburb

Description: The name of the locality/suburb of the address, as represented by text where the patient normally resides.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 429889

1.16. State/Territory

Description: An identifier of the state or territory of an address where the patient normally resides, as represented by a code.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 722751

1.17. Postcode

Description: The Australian numeric descriptor for a postal delivery area for an address where the patient normally resides.

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 611398

1.18. Postal address is the same as residential address

Description: To differentiate between patient's Residential and Postal address.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

1.19. Street

Description: The name of the road applicable to the address site or complex, as represented by text where the patient receives their mail, can be house number or PO BOX,

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 429747

1.20. Suburb

Description: The name of the locality/suburb of the address, as represented by text, where the patient receives their mail.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 429889

1.21. State/Territory

Description: An identifier of the state or territory of an address, where the patient receives their mail, as represented by a code.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 722751

1.22. Postcode

Description: The Australian numeric descriptor for a postal delivery area for an address.
Purpose: Registration Requirement
Data Obligation: Non-Mandatory
Data Collection: Derived
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 611398

1.23. Landline number (incl. area code)

Description: The patient's contact home telephone number
Purpose: Registration Requirement
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 611164

1.24. Mobile number

Description: The patient's contact mobile number
Purpose: Registration Requirement
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270266

1.25. Email

Description: The patient's electronic internet contact address, used for communication purposes, as represented by text.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 452649

1.26. First Name (Parent/Guardian)

Description: If patient is Under 18, then Parent or Guardian's given name(s) as stated in medical records

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 613340

1.27. Last Name (Parent/Guardian)

Description: If patient is Under 18, then, Parent or Guardian's last name as stated in medical records

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 613331

1.28. Preferred language (Parent/Guardian)

Description: The language (including sign language) most preferred by the person for communication, as represented by a code for the Parent or Guardian

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Bureau of Statistics 2016a. Australian Standard Classification of Languages (ASCL) 2016. ABS cat. no.1267.0. Canberra: ABS
https://www.abs.gov.au/statistics/classifications/australian-standard-classification-languages-ascl/latest-release

METEOR identifier: 659407

1.29. Parent/Guardian postal address is the same as patient's residential address

Description: To differentiate between patient's Parent or Guardian's correspondence address.

Purpose: Registration Requirement

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

1.30. Pre-op hospital/Clinic name

Description: Location where preoperative assessment and counselling performed - Private rooms or hospital clinic

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)

METEOR identifier: 743283

1.31. Surgery related to which Pelvic Floor Disorder

Description: Clinical indication for procedure performed.
Purpose: Registration Requirement
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

1.32. Planned date of surgery

Description: Date when the procedure is planned to commence
Purpose: Registration Requirement
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270298

1.33. Planned date of surgery - Estimate

Description: Estimate date of procedure being performed if no actual date is set
Purpose: Registration Requirement
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270299

1.34. The revised surgery date (If Surgery Postponed)

Description: New date of surgery when surgery was postponed
Purpose: Registration Requirement
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270300

1.35. Planned hospital name

Description: Where procedure is to be performed
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 407430

1.36. Planned Surgeon Name

Description: Name of consultant surgeon who plans to perform or supervise the procedure
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 620370

1.37. Planned Surgeon Name (Consultant) - Other

Description: Name of consultant surgeon who plans to perform or supervise the procedure if not mentioned in the above list

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 620371

1.38. Declaration

Description: Informing individual (Hospital/Surgeon) entering data about the completion and correctness of form and confirming that patient can be contacted about being in the registry

Purpose: Registration Requirement

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2. Clinical History and Surgery Details

2.1. Procedure type

Description: Clinical indication for procedure performed

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Adapted from BSUG, BAUS, TVT, DUD, Swedish GYNop, SDD, TMR, VIGI-MESH, PMD, https://www.ics.org/glossary/symptom/stressurinaryincontinence?q=Stress%20Urinary%20Incontinence

2.2. SUI Surgery Type

Description: SUI surgery type represents procedure to treat SUI or a complication from previous SUI surgery.

SUI procedure type is defined as a procedure performed to treat SUI- "Complaint of involuntary loss of urine on effort or physical exertion including sporting activities, or on sneezing or coughing" or complication from previous SUI surgery.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA / ICS joint report on the terminology for pelvic floor dysfunction. IUJ 2010;21,5-26

2.3. POP Surgery Type

Description:	POP surgery type represents procedure to treat POP or a procedure to treat a complication from previous POP surgery. POP procedure defined as procedure to treat "Diagnosis by symptoms and clinical examination, assisted at times by any relevant imaging (i.e. clinically evident): 1. Uterine/ cervical prolapse: Clinically evident descent of the uterus or uterine cervix. 2. Anterior vaginal wall (compartment) prolapse: Clinically evident descent of the anterior vaginal wall (compartment). 3. Posterior vaginal wall (compartment) prolapse: Clinically evident descent of the posterior vaginal wall (compartment). 4. Vaginal vault (cuff scar) prolapse: Clinically evident descent of the vaginal vault (cuff scar after hysterectomy)."
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/diagnosis/pelvicorganprolapseclinicaldiagnosis?q=Pelvic%20Organ%20Prolapse

2.4. SUI Prosthesis surgery complication type

Description:	Mesh Complication Classification System (MCCS) by Category Timing and Site, using the International Continence Society standardised terminology and classification for complications directly related to insertion of synthetic (mesh and biological (grafts) in female pelvic floor surgery, including - Voiding dysfunction - Overactive Bladder Syndrome - Recurrent Urinary Tract Infections (UTIs) - Persistent pelvic and associated pain - Any other prosthesis (not MCCS Code) or non-prosthesis related complication
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/complication

2.5. Other prosthesis or non-prosthesis related complication

Description: Other prosthesis or non-prosthesis complication
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/complication

2.6. Mesh Complication Classification System (MCCS): Complication Reporting Terminologies [2.6.1 - 2.6.17]

2.6.1. MCCS CATEGORY

Description: The selection of category and subdivision has used the principle that the least severe complication would involve the prosthesis remaining within the anatomical site into which it was inserted. More severe complications would involve (i) an increasing migration / protrusion into surrounding anatomical structures; (ii) opening into surrounding organs; and (iii) systemic in the format of Category(C): 1-7 (Organ/s involved) Division(D): A-C (Symptoms, Type and Severity of complication) Pain(p): a-e (presence and associated provocatory activity) Time (T): 1-4 (Time period (Perioperative 48 hours, >48 hours to 2 months, >2 months to 12 months, >12 months) at which complication clinically diagnosed) Site(S): Proximity of complication site to prosthesis

Exclusions: The MCCS does not capture the following complications - Type of mesh, Functional issues e,g, overactive bladder syndrome, voiding dysfunction except for urinary retention, Urinary Tract Infections, SUI/POP recurrence, Intraperitoneal adhesions or Bulking agents.

https://www.ics.org/complication site enables calculation of code, in the format CDpTxSy e,g, 2Bc-T3-S1 - Small mesh exposure with symptoms and dyspareunia diagnosed at between 2 and 12 months and at the vaginal suture line

Purpose:
Data Obligation: Non-Mandatory
Data Collection: N/A
Data Source, Standard / Terminology / Code set in use:

Haylen BT, Freeman RM, Swift SE, Cosson M, Davila GW, Deprest J, Dwyer PL, Fatton B, Kocjancic E, Lee J, Maher C. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint terminology and classification of the complications related directly to the insertion of prostheses (meshes, implants, tapes) & grafts in female pelvic floor surgery. International Urogynecology Journal. 2011 Jan;22:3-15.

2.6.2. DIVISION (CATEGORY 1)

Description: Using the MCCS, vaginal complication with no epithelial penetration with Division, Pain, Time and Site as per MCC Category

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.3. DIVISION (CATEGORY 2 OR 3):

Description: Using the MCCS, vaginal complication with <= 1cm exposure (2) or >1cm exposure or extrusion (3), with Division, Pain, Time and Site as per MCC Category

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.4. DIVISION (CATEGORY 4):

Description: Using the MCCS, compromise or perforation of urinary tract, including prosthesis/graft, fistula and calculus

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.5. DIVISION (CATEGORY 5):

Description: Using the MCCS, compromise or perforation of rectum or bowel, including prosthesis/graft and fistula

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.6. DIVISION (CATEGORY 6):

Description: Using the MCCS, skin and/or musculoskeletal complication, including discharge, pain, lump or sinus tract formation

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.7. DIVISION (CATEGORY 7):

Description: Using the MCCS, patient compromise including hematoma or systemic compromise

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.8. MCCS CATEGORY DIVISION CALCULATION

Description: Calculated code MCCS Division (Sub classification of Category) - A-C (Symptoms, Type and Severity of complication), varying based on Category using https://www.ics.org/complication

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.9. MCCS DIVISION CALCULATION

Description: Calculated code MCCS Division (Sub classification of Category) - A-C (Symptoms, Type and Severity of complication), varying based on Category using https://www.ics.org/complication

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.10. PAIN:

Description: Subclassification of Complication Categories to specify pain symptoms and associated provocatory activitiy

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.11. PAIN (CALCULATED):

Description: Calculated code value of Pain for MCCS, using https://www.ics.org/complication

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.12. TIME AT DIAGNOSIS

Description: The time for the complication is when it is clinically diagnosed by four time periods T1-4 (Time period (Perioperative 48 hours, >48 hours to 2 months, >2 months to 12 months, >12 months)

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.13. TIME AT DIAGNOSIS (CALCULATED):

Description: Calculated code value of Time of Diagnosis for MCCS, using https://www.ics.org/complication

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.14. SITE:

Description: Proximity of complication site (S) to prosthesis

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.15. SITE (CALCULATED):

Description: Calculated code value of Site for MCCS, using https://www.ics.org/complication

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.16. MCCS CODE CALCULATION

Description: Complication code including Category, Division, Pain, Time and Site in the format CDpTxSy using https://www.ics.org/complication e,g, 2Bc-T3-S1 - Small mesh exposure with symptoms and dyspareunia diagnosed at between 2 and 12 months and at the vaginal suture line

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

IUGA/ICS Joint Terminology and Classification of Complications Related Directly to the Insertion of Prostheses (Meshes, Implants, Tapes) or Grafts In Female Pelvic Floor Surgery, https://www.ics.org/complication

2.6.17. TICK TO ENTER MORE MCCS CODE

Description: Option to enter multiple codes if the patient has multiple complications
Purpose: Assessment/Diagnostic Info
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.7. POP-Q Assessment Terminologies [2.7.1- 2.7.12]

2.7.1. ANTERIOR (BA)

Description: A point that represents the most distal (i.e., most dependent) position of any part of the upper anterior vaginal wall from the vaginal cuff or anterior vaginal fornix to point Aa. By definition, point Ba is at -3 cm in the absence of prolapse and would have a positive value equal to the position of the cuff in women with total posthysterectomy vaginal eversion.
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17
Pop Q tool, https://pop-q.netlify.app/

2.7.2. ANTERIOR CALC

Description: Ordinal staging of anterior compartment (0-4), based on Anterior (Ba)
Purpose: Assessment/Diagnostic Info
Data Obligation: Non-Mandatory
Data Collection: Derived
Data Source, Standard / Terminology / Code set in use:
Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17
Pop Q tool, https://pop-q.netlify.app/

2.7.3. APICAL CALC

Description: Ordinal staging of apical compartment (0-4), based on Apical (C - Uterus or vault)

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.4. BLADDER NECK (AA)

Description: A point located in the middle of the anterior vaginal wall three (3) cm proximal to the external urethral meatus. By definition, the range of position of Point Aa relative to the hymen is -3 to +3cm.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.5. POSTERIOR CALC

Description: Ordinal staging of posterior compartment (0-4), based on Posterior (Bp)

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Derived

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.6. APICAL (C - UTERUS OR VAULT)

Description: A point that represents either the most distal (i.e., most dependent) edge of the cervix or the leading edge of the vaginal cuff (hysterectomy scar) after total hysterectomy

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.7. CUL DE SAC (D - ONLY IF HAS UTERUS)

Description: A point that represents the location of the posterior fornix in a woman who still has a cervix. It is included as a point of measurement to differentiate suspensory failure of the uterosacral-cardinal ligament "complex" from cervical elongation. When the location of Point C is significantly more positive than the location of Point D, this is indicative of cervical elongation which may be symmetrical or eccentric. Point D is omitted in the absence of the cervix.

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.8. LOWER POSTERIOR (AP)

Description: A point located in the midline of the posterior vaginal wall three (3) cm proximal to the hymen. By definition, the range of position of Point Ap relative to the hymen is -3 to +3 cm.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.9. POSTERIOR (BP)

Description: Diagnosis point that represents the most distal (i.e., most dependent) position of any part of the upper posterior vaginal wall from the vaginal cuff or posterior vaginal fornix to point Ap. By definition, point Bp is at-3 cm in the absence of prolapse and would have a positive value equal to the position of the cuff in a woman with total posthysterectomy vaginal eversion.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.10. GENITAL

Description: The genital hiatus (GH) is measured from the middle of the external urethral meatus to the posterior margin of the hymen.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.11. PERINEAL BODY (PB)

Description: The perineal body (PB) is measured from the posterior margin of the hymen to the mid-anal opening.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.7.12. TOTAL VAGINAL LENGTH

Description: The total vaginal length (TVL) is the length of the vagina (cm) from the posterior fornix to hymen when Point C or D is reduced to its full normal position.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Reference: Bump RC, Mattiasson A, Bø K, Brubaker LP, DeLancey JOL, Klarskov P, Shull BL, Smith ARB (1996) The standardisation of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol 175:10–17

Pop Q tool, https://pop-q.netlify.app/

2.8. POP symptoms

Description: Complaints by a woman in reference to the position (descent) of her pelvic organs. Symptoms are generally worse at the times when gravity might make the prolapse worse (e.g. after long periods of standing or exercise) and better when gravity is not a factor, e.g. lying supine.

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/pelvicorganprolapsepopsymptoms?q=pop%20symptoms

2.9. Need to reduce- reason

Description: Patient reason if there is the complaint of splinting/digitation i.e. digitally replace the prolapse or to otherwise apply manual pressure, for example, to the vagina or perineum (splinting), or to the vagina or rectum (digitation) to assist voiding or defecation.

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/splintingdigitationduetopop?q=splinting

2.10. Bowel symptoms/obstruction

Description: Obstructed defecation: incomplete evacuation of faecal contents from rectum due to physical blockage of the faecal stream during defecation attempts. It includes symptoms such as straining to defecate, sensation of blockage, digitation, and splinting.

Purpose: Risk adjustment, Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/diagnosis/obstructeddefecationsyndrome?q=bowel

2.11. Duration of prolapse symptoms (months)

Description: Duration of time of prolapse symptoms in months

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.12. Topical vaginal oestrogen and its Indication

Description: Use of a topical vaginally applied oestrogen for the mangagement of SUI or POP symptoms, as part of first line management of pelvic floor conditions can be either Hormone replacement or Treatment of mesh exposure

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Tzur T, Yohai D, Weintraub AY. The role of local estrogen therapy in the management of pelvic floor disorders. Climacteric. 2016 Mar 3;19(2):162-71.

2.13. Urinary incontinence present

Description: Complaint of involuntary loss of urine.

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/urinaryincontinence?q=Urinary%20Incontinence

2.14. Duration of urinary symptoms (months)

Description: Duration of time of urinary incontinence symptoms (months)

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.15. Does the patient have overactive bladder syndrome?

Description:	Complaint of urinary urgency, usually accompanied by increased daytime frequency and/or nocturia, with urinary incontinence (OAB-wet) or without (OAB-dry), in the absence of urinary tract infection or other detectable disease.
Purpose:	Risk adjustment
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/overactivebladderoaburgencysyndrome?q=Overactive%20bladder

2.16. Objective evidence of stress urinary incontinence

Description:	Observation of involuntary leakage from the urethral orifice synchronous with effort or physical exertion, or on sneezing or coughing.
Purpose:	Risk adjustment
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/sign/stressurinaryincontinenceclinicalstressleakage?q=Stress%20urinary

2.17. Method of objective assessment of SUI

Description:	Method used to diagnose SUI - Cough Stress Test (CST) Urodynamic studies (UDS) Pad Test Cough test with prolapse reduction Other, please specify: Not known Not Done
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Abrams P, Andersson KE, Apostolidis A, Birder L, Bliss D, Brubaker L, Cardozo L, Castro-Diaz D, O'connell PR, Cottenden A, Cotterill N. 6th International Consultation on Incontinence. Recommendations of the International Scientific Committee: evaluation and treatment of urinary incontinence, pelvic organ prolapse and faecal incontinence. Neurourology and urodynamics. 2018;37(7):2271-2.

2.18. Method of objective assessment of SUI - Other

Description: Method used to diagnose SUI - Other - Free text
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.19. Urodynamic studies (UDS) Testing result

Description: Urodynamic testing diagnosis:
Urodynamic stress incontinence
Detrusor overactivity
Abdominal leak point pressure,
Maximum urethral closure pressure
Voiding dysfunction
Urethral mobility
Not performed
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
Haylen BT, De Ridder D, Freeman RM, Swift SE, Berghmans B, Lee J, Monga A, Petri E, Rizk DE, Sand PK, Schaer GN. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction. Neurourology and Urodynamics: Official Journal of the International Continence Society. 2010 Jan;29(1):4-20.

2.20. Dyspareunia

Description: Complaint of persistent or recurrent pain or discomfort associated with attempted or complete vaginal penetration.
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
https://www.ics.org/glossary/symptom/dyspareunia?q=dyspareunia ,
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

2.21. Persistent pelvic and associated pain

Description:	Chronic pelvic pain is characterised by persistent pain lasting longer than 6 months or recurrent episodes of abdominal/pelvic pain, hypersensitivity or discomfort often associated with elimination changes, and sexual dysfunction often in the absence of organic aetiology.
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting, https://www.ics.org/glossary/diagnosis/chronicpelvicpain?q=pelvic%20pain

2.22. Regions of persistent pelvic and associated pain occurs

Description:	Chronic pelvic pain - Characteristics Symptom, defined by ICS as: a: Duration of pain: Six months or more of persistent pain. b. Location of pain: Pelvis, lower abdomen, low back, medial aspect of thigh, inguinal area, perineum. c. Perception of pain: Patients may describe the pain as sharp, burning, aching, shooting, stabbing, pressure or discomfort, sexual pain (dyspareunia). d. Modality of pain: Persistent and/or continuous, recurrent and/or episodic and/or cyclic (related to menstrual cycle).
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/chronicpelvicpaincharacteristics?q=pelvic%20pain ,
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting,
https://www.safetyandquality.gov.au/our-work/health-conditions-and-treatments/transvaginal-mesh/resources-consumers-clinicians-and-health-service-organisations-transvaginal-mesh-and-sacrocolpopexy

2.23. Regions of persistent pelvic and associated pain occurs - Other

Description: Chronic Pelvic Pain - Characteristics
Symptom, defined by ICS as:
a: Duration of pain: Six months or more of persistent pain. b. Location of pain: Pelvis, lower abdomen, low back, medial aspect of thigh, inguinal area, perineum. c. Perception of pain: Patients may describe the pain as sharp, burning, aching, shooting, stabbing, pressure or discomfort, sexual pain (dyspareunia). d. Modality of pain: Persistent and/or continuous, recurrent and/or episodic and/or cyclic (related to menstrual cycle).

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting, https://www.ics.org/glossary/diagnosis/chronicpelvicpain?q=pelvic%20pain

2.24. Persistent pelvic and associated pain occurs

Description: Provocatory activity causing pain: Unspecified
When provoked
During sexual intercourse
During physical activities
Spontaneously

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

2.25. Recurrent Urinary Tract Infections

Description:	Recurrent urinary tract infections (UTI): A diagnosis by clinical history assisted by the results of diagnostic tests involves the determination of the occurrence of at least three symptomatic and medically diagnosed urinary tract infections (UTI) over the previous 12 months
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/chronicpelvicpaincharacteristics?q=pelvic%20pain ,

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting,

https://www.safetyandquality.gov.au/our-work/health-conditions-and-treatments/transvaginal-mesh/resources-consumers-clinicians-and-health-service-organisations-transvaginal-mesh-and-sacrocolpopexy

2.26. Voiding dysfunction

Description:	A diagnosis by symptoms and urodynamic investigations is defined as abnormally slow and/or incomplete micturition, based on abnormal slow urine flow rates and/or abnormally high post void residuals, ideally on repeated measurement to confirm abnormality.
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/diagnosis/possibleprolapserelateddiagnoses?q=voiding%20dysfunction

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

2.27. Assessment methods

Description:	Voiding dysfunction assessment method: Post-void residual Uroflow In/Out catheter
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting, https://www.safetyandquality.gov.au/our-work/health-conditions-and-treatments/transvaginal-mesh/resources-consumers-clinicians-and-health-service-organisations-transvaginal-mesh-and-sacrocolpopexy

2.28. Does patient require a catheter?

Description:	Whether urinary catheter required to manage voiding dysfunction, as a safety and risk adjustment variable. Can be one of 1. Yes, 2. NO, 3. Not Known
Purpose:	Risk adjustment, Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.29. Catheter Type

Description:	If catheter is required then which type of urinary catheter - indwelling, suprapubic or in/out catheter
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.30. Height (cm)

Description: The height of a person measured in centimetres.
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270361

2.31. Weight (kg)

Description: The weight (body mass) of a person measured in kilograms.
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 702085

2.32. Body Mass Index

Description: A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where height and weight have been measured.
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon, Derived
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270084

2.33. Smoking status

Description: A person's current and past smoking behaviour.
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 270311

2.34. Diabetes present

Description: Identifies a person with or at risk of diabetes.
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR Identifier: 269659

2.35. Post-menopausal

Description: Yes/No options with women >45 years with menopausal symptoms in women who have not had a period for at least 12 months and are not using hormonal contraception
or menopause based on symptoms in women without a uterus.
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://www.nice.org.uk/guidance/ng23/chapter/Recommendations#diagnosis-of-perimenopause-and-menopause

2.36. Previous POP surgery

Description: Yes/No indicating if patient has had previous POP surgery
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.37. Previous POP procedure

Description: Yes/No indicating if patient has had previous POP procedure
Purpose: Risk adjustment
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.38. First line management of mesh complication

Description: Indicator of whether patient has had first line non-surgical management of mesh complications
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/management-of-mesh-and-graft-complications-in-gynecologic-surgery

2.39. Specify management attempted

Description: First line management of mesh complications
Pelvic floor physiotherapy
Pharmacological intervention

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/management-of-mesh-and-graft-complications-in-gynecologic-surgery

2.40. Please specify Pharmacological intervention

Description: Type of pharmacological intervention:
Analgesics
Topical vaginal oestrogen

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/management-of-mesh-and-graft-complications-in-gynecologic-surgery

2.41. Hormone replacement

Description: Patient currently taking Hormone replacement: Yes/No

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.42. Mode delivery - Normal

Description: Number of vaginal births without instrumental assistance.
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://meteor.aihw.gov.au

2.43. Mode delivery - Vacuum

Description: Number of Instrumental births using vacuum extraction to assist the baby to come out through the vagina.
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://meteor.aihw.gov.au

2.44. Mode delivery - Forceps

Description: Number of Instrumental births using forceps to assist the baby to come out through the vagina.
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://meteor.aihw.gov.au

2.45. Mode delivery – Caesarean

Description: Number of births via caesarean section
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://meteor.aihw.gov.au

2.46. Mode delivery - Nulliparous

Description: No births previously
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

https://meteor.aihw.gov.au

2.47. Surgery performed

Description: Indicator of planned surgery performed: Yes/No
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.48. Reason for surgery not being performed

Description: Reason for whether planned procedure was not performed or completed,

- Patient unfit for surgery or anaesthetic
- Patient's symptoms resolved, no need for surgery
- Patient refused surgery/No show
- Patient deceased
- Other, please specify
- Reason not known

Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)

2.49. Date of death

Description: If surgery not performed and if reason is death, date of death is sought. The date upon which a person ceases to live, expressed as DDMMYYYY.

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 646025

2.50. Date of death - Estimate

Description: The date upon which a person ceases to live, expressed as YYYY.

Purpose: Risk adjustment

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 646025

2.51. Reason for surgery not being performed- Other

Description: Other reason for whether planned procedure was not performed or completed

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.52. Surgery date

Description: Date when the procedure is occurred.

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.53. Hospital

Description: Hospital where procedure is performed
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Australian Institute of Health and Welfare (AIHW)
METEOR identifier: 407430

2.54. Surgeon Name (Consultant)

Description: Name of consultant surgeon who performs or supervises the procedure.
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.55. Surgeon Name (Consultant) - Other

Description: Name of consultant surgeon who performs or supervises the procedure if not mentioned in the above list
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.56. Category of surgery undertaken

Description: Type of surgery performed:
SUI surgical prosthesis implantation
Bulking agent injection
Surgery for complication/s from previous SUI procedure
Prolapse surgery
Hysterectomy
Perineorrhaphy
Additional POP procedure
Surgery for complication/s from previous POP procedure
Patient request (asymptomatic SUI prosthesis removal)
Patient request (asymptomatic POP prosthesis removal)
SUI Native Tissue Procedure, please specify
Other, please specify

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

2.57. SUI Native Tissue Procedure - Please specify

Description: If native tissue SUI procedure performed - Name

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.58. ASA Score

Description: American Society of Anaesthesiologists Physical Status Classification System for classifying pre-anaesthetic co-morbidities: (I-IV)

Purpose: Risk adjustment

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.asahq.org/~/media/sites/asahq/files/public/resources/standards-guidelines/asa-physical-status-classification-system.pdf

2.59. Cystoscopy performed

Description: Endoscopy of the urethra and urinary bladder via the urethra
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
Australian Institute of Health and Welfare (AIHW)

2.60. POP Surgery with implant/prosthesis compartment - Anterior Treated

Description: Indicates if anterior compartment prolapse procedure performed- Yes, No
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.61. Anterior Approach

Description: Indicates route of anterior compartment prolapse repair - abdominal, vaginal
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.62. Anterior Implant Used

Description: Indicates if prosthesis used to treat anterior compartment prolapse - Yes, No
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.63. POP Surgery with implant/prosthesis compartment - Posterior Treated

Description: Indicates if posterior compartment prolapse procedure performed- Yes, No
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.64. Posterior Approach

Description: Indicates route of posterior compartment prolapse repair - abdominal, vaginal
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.65. Posterior Implant

Description: Indicates if prosthesis used to treat anterior compartment prolapse - Yes, No
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.66. POP Surgery with implant/prosthesis compartment - Apical Treated

Description: Indicates if apical compartment prolapse procedure performed- Yes, No
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.67. Apical Approach

Description: Indicates route of apical compartment prolapse repair - abdominal, vaginal
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.68. Apical Implant

Description: Indicates if prosthesis used to treat apical compartment prolapse - Yes, No
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

2.69. Anterior Implant type

Description: If prosthesis used to perform anterior compartment prolapse, type of implant -
Synthetic Mesh
Autologous graft - dura mater, rectus sheath or fascia lata
Allograft - post mortem tissue bank
Xenograft - Modified porcine dermis, porcine small intestine, bovine pericardium
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

Haylen BT, Freeman RM, Swift SE, Cosson M, Davila GW, Deprest J, Dwyer PL, Fatton B, Kocjancic E, Lee J, Maher C. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint terminology and classification of the complications related directly to the insertion of prostheses (meshes, implants, tapes) & grafts in female pelvic floor surgery. International Urogynecology Journal. 2011 Jan;22:3-15.

2.70. Anterior POP Prosthesis (Billing Code, Product Name)

Description: Anterior Product identifier
Purpose: Device information
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
Manufacturer

2.71. Anterior implant batch number

Description: Anterior Product manufacture identifier
Purpose: Device information
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
Manufacturer

2.72. Anterior new device use within the context of a clinical trial

Description: Whether anterior device is being used as part of a clinical trial: Yes, No
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.73. Posterior Implant type

Description: If prosthesis used to perform posterior compartment prolapse, type of implant –

- Synthetic Mesh
- Autologous graft - dura mater, rectus sheath or fascia lata
- Allograft - post mortem tissue bank
- Xenograft - Modified porcine dermis, porcine small intestine, bovine pericardium

Purpose: Device information

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Haylen BT, Freeman RM, Swift SE, Cosson M, Davila GW, Deprest J, Dwyer PL, Fatton B, Kocjancic E, Lee J, Maher C. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint terminology and classification of the complications related directly to the insertion of prostheses (meshes, implants, tapes) & grafts in female pelvic floor surgery. International Urogynecology Journal. 2011 Jan;22:3-15.

2.74. Posterior POP Prosthesis (Billing Code, Product Name)

Description: Posterier Product identifier

Purpose: Device information

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.75. Posterior implant batch number

Description: Posterior product manufacturer identifier

Purpose: Device information

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.76. Posterior new device use within the context of a clinical trial

Description: Indicator of whether posterior device used in clinical trial - Yes/no

Purpose: Device information

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.77. Apical Implant type

Description: If prosthesis used to perform apical compartment prolapse, type of implant -

- Synthetic Mesh
- Autologous graft - dura mater, rectus sheath or fascia lata
- Allograft - post mortem tissue bank
- Xenograft - Modified porcine dermis, porcine small intestine, bovine pericardium

Purpose: Device information

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

Haylen BT, Freeman RM, Swift SE, Cosson M, Davila GW, Deprest J, Dwyer PL, Fatton B, Kocjancic E, Lee J, Maher C. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint terminology and classification of the complications related directly to the insertion of prostheses (meshes, implants, tapes) & grafts in female pelvic floor surgery. International Urogynecology Journal. 2011 Jan;22:3-15.

2.78. Apical POP Prosthesis (Billing Code, Product Name)

Description: Apical Product identifier

Purpose: Device information

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.79. Apical implant batch number

Description: Apical Product manufacture identifier
Purpose: Device information
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.80. Apical new device use within the context of a clinical trial

Description: Whether posterior device is being used as part of a clinical trial: Yes, No
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.81. SUI Prosthesis complication surgery type

Description: Type of surgery to treat previous SUI prosthesis complication:
- Sling division
- Vaginal mesh revision (no excision)
- Partial vaginal mesh excision
- Complete vaginal mesh excision
- Extra-vaginal mesh excision
- Total mesh excision
- Bulking agent removal

Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/management-of-mesh-and-graft-complications-in-gynecologic-surgery

2.82. Indication for surgical treatment of SUI prosthesis complication

Description: Indication for treatment of SUI prosthesis complication:

- Voiding dysfunction
- Infection
- Mesh exposure (patient reported)
- Pain
- Haemorrhage
- Asymptomatic
- Clinician observed exposure (on examination)
- Patient request
- Other

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting. https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-of-Senior-Medical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Surgery-for-Pelvic-Organ-Prolapse.pdf

2.83. Surgical treatment type for POP mesh complication - Mesh graft complication

Description: Type of surgery to treat previous POP prosthesis complication:
Vaginal mesh revision (no excision)
Partial vaginal mesh excision
Complete vaginal mesh excision
Extra-vaginal mesh excision
Total mesh excision

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/management-of-mesh-and-graft-complications-in-gynecologic-surgery

2.84. Indication for surgical treatment of POP mesh complication

Description: Indication for treatment of POP prosthesis complication:
Voiding dysfunction
Infection
Mesh exposure
Pain
Haemorrhage
Asymptomatic
Clinician observed exposure
Patient request
Other

Purpose: Surgical/procedural

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting.
https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-of-Senior-Medical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Surgery-for-Pelvic-Organ-Prolapse.pdf

2.85. SUI Prosthesis (Billing Code, Product Name)

Description: SUI Product identifier

Purpose: Device information

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.86. Other - Manufacturer

Description: SUI Product manufacturer

Purpose: Device information

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

2.87. Other - Model/Brand Name

Description: SUI Product model/Brand name
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.88. Batch number

Description: SUI Product manufacture identifier
Purpose: Device information
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.89. Intraoperative complications during SUI or POP procedure?

Description: Indicator of complication during SUI or POP procedure - Yes, No
Purpose: Outcomes
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

2.90. SUI or POP intraoperative complication type

Description: SUI or POP Intraoperative complication type:
MCCS coded complication
Blood loss > 500 ml
Other prosthesis (Not MCCS Coded) or non-prosthesis related complication

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting,
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/guidance-hospital-credentialing-senior-medical-practitioners-undertake-transvaginal-mesh-surgery-stress-urinary-incontinence
https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-of-Senior-Medical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Surgery-for-Pelvic-Organ-Prolapse.pdf

2.91. Other prosthesis or non-prosthesis related complication

Description: Complication related to procedure, either involving or not involving the prosthesis, not captured by the MCCS

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting,
https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-of-Senior-Medical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Surgery-forStress-Urinary-Incontinence.pdf

2.92. Intraoperative complication reported to TGA

Description: Indication of whether intraoperative complication has been reported to the Therapeutic Goods Administration at https://www.tga.gov.au/safety/reporting-problems

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

As per TGA Reporting Problems site: https://www.tga.gov.au/safety/reporting-problems

2.93. TGA - Report number

Description: Report number provided by https://www.tga.gov.au/safety/reporting-problems when a report is submitted

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

As per TGA Reporting Problems site: https://www.tga.gov.au/safety/reporting-problems

2.94. Complication type (POP Mesh)

Description: Type of complication

- Prosthesis related complication (MCCS Coded),
- Persistent pelvic and associated pain,
- Other prosthesis (not MCCS Code) or non-prosthesis related complication

Purpose: Assessment/Diagnostic Info

Data Obligation: Non-Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/complication,
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting.
Ref: https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-of-Senior-Medical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Surgery-for-Pelvic-Organ-Prolapse.pdf

3. Postoperative Visit (1st and 2nd)

3.1. Patient attended a postoperative follow up

Description: Indicator whether patient attended for follow-up - Yes / No
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.2. Reason patient did not attend a postoperative follow up

Description: Reason if patient did not attend
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.3. Mortality within 30 days of surgery

Description: Patient ceases to live within 30 days of SUI or POP procedure
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.4. Mortality related to surgery

Description: Patient ceases to live related to procedure
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.5. Mortality related to surgery - Detail

Description: Patient ceases to live related to procedure details
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.6. Reason patient not attend - Other

Description: Reason for patient not attending
Purpose: Outcomes
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.7. Date of postoperative follow up

Description: Date of postoperative follow-up, expressed as DDMMYYYY.
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.8. SUI or POP outcome status

Description: Outcome of SUI or POP procedure
Improved
Same
Worse
Not evaluated

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.9. Voiding dysfunction outcome

Description: Outcome of mesh complication procedure for treating voiding dysfunction:
Resolved
Improved
Same as prior to surgery
Worse
Not evaluated

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.10. Infection outcome

Description: Outcome of mesh complication procedure for treating infection:
Resolved
Improved
Same as prior to surgery
Worse
Not evaluated

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.11. Mesh Exposure outcome

Description:	Outcome of mesh complication procedure for treating mesh exposure: Resolved Improved Same as prior to surgery Worse Not evaluated
Purpose:	Outcomes
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.12. Pain outcome

Description:	Outcome of mesh complication procedure for treating pain: Resolved Improved Same as prior to surgery Worse Not evaluated
Purpose:	Outcomes
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.13. Haemorrhage outcome

Description:	Outcome of mesh complication procedure for treating haemorrhage: Resolved Improved Same as prior to surgery Worse Not evaluated
Purpose:	Outcomes
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.14. Asymptomatic outcome

Description:	Outcome of mesh complication procedure for treating asymptomatic complication: Resolved Improved Same as prior to surgery Worse Not evaluated
Purpose:	Outcomes
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.15. Clinician outcome

Description:	Outcome of mesh complication procedure for treating clinician identified complication: Resolved Improved Same as prior to surgery Worse Not evaluated
Purpose:	Outcomes
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.16. Patient requested outcome

Description:	Outcome of mesh complication procedure for patient requested treatment: Resolved Improved Same as prior to surgery Worse Not evaluated
Purpose:	Outcomes
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.17. Other outcome

Description: Outcome of mesh complication procedure for treating other complication:
Resolved
Improved
Same as prior to surgery
Worse
Not evaluated

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.18. Return to theatre prior to discharge

Description: Indicator of return to theatre prior to discharge - Yes No

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.19. Return to theatre prior to discharge - Reason

Description: Reason for return to theatre prior to discharge

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.20. Readmission to hospital within 30 days of any surgery

Description: Indicator of readmission to hospital within 30 days of surgery (Yes/No).
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.21. Readmission to hospital within 30 days of surgery - Reason

Description: Reason for return to hospital within 30 days of surgery
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.22. Patient discharged requiring catheterisation?

Description: Patient discharged from hospital following procedure requiring catheter to manage voiding dysfunction - Yes / No
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.23. Catheter type

Description: Type of catheter:
Indwelling Catheter (IDC)
Suprapubic Catheter (SPC)
Self Catheterisation
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:

N/A

3.24. Catheter still required?

Description: Catheter still required at follow-up
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.25. Clinician assessment of POP improvement

Description: Clinician assessment of POP symptom improvement:
Very much improved
Improved
No change
Worse that prior to the operation
Very much worse than prior to the operation
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting, https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-of-Senior-Medical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Surgery-for-Pelvic-Organ-Prolapse.pdf

3.26. Was a vaginal exam done to assess for exposure or pain?

Description: Indicator of whether vaginal exam performed at assessment to identify complication including exposure or pain - Yes / No
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.27. Were the Intraoperative complications during the SUI and/or POP procedure resolved?

Description: If intraoperative complication, indicator of whether persisting problems related to complication - Yes / No

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting,
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/guidance-hospital-credentialing-senior-medical-practitioners-undertake-transvaginal-mesh-surgery-stress-urinary-incontinence

3.28. SUI/ POP complication?

Description: Indicator of whether SUI/POP complicaiton or - Yes / No

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

3.29. Complication type

Description: Type of complication
MCCS Coded Complication
Blood loss > 500 ml
Sepsis (infection only covered by MCCS code below)
Other prosthesis (Not MCCS Coded) or non-prosthesis related complication

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting.
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/guidance-hospital-credentialing-senior-medical-practitioners-undertake-transvaginal-mesh-surgery-stress-urinary-incontinence

3.30. Other prosthesis or non-prosthesis complication

Description: Non-MCCS related or non-prosthesis related complication description
Purpose: Outcomes
Data Obligation: Non-Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
As per TGA Reporting Problems site: https://www.tga.gov.au/safety/reporting-problems

3.31. Voiding function complication status

Description: States of voiding dysfunction:
Normal
Impaired
Retention
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.32. Is surgical treatment required

Description: Indicator of whether surgical treatment required to treat voiding dysfunction:
Yes, please specify date of planned surgery
No
Purpose: Assessment/Diagnostic Info
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.33. Did patient have urethral dilation to loosen the sling?

Description:	Indicator of whether voiding dysfunction treated with uretheral dilation to loosen sling: Yes/No
Purpose:	Surgical/procedural
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting, https://www.safetyandquality.gov.au/our-work/health-conditions-and-treatments/transvaginal-mesh/resources-consumers-clinicians-and-health-service-organisations-transvaginal-mesh-and-sacrocolpopexy

3.34. Overactive bladder syndrome

Description:	Complaint of Urinary urgency, usually accompanied by increased daytime frequency and/or nocturia, with urinary incontinence (OAB-wet) or without (OAB-dry), in the absence of urinary tract infection or other detectable disease.
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/chronicpelvicpaincharacteristics?q=pelvic%20pain ,
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.35. Recurrent urinary tract infections (UTIs)

Description:	This diagnosis by clinical history assisted by the results of diagnostic tests involves the determination of the occurrence of at least three symptomatic and medically diagnosed urinary tract infections (UTIs) over the previous 12 months.
Purpose:	Assessment/Diagnostic Info
Data Obligation:	Mandatory
Data Collection:	Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/diagnosis/recurrenturinarytractinfectiondiagnosisfemale?q=Recurrent%20UTI

3.36. Regions of persistent pelvic and associated pain occurs

Description: Chronic Pelvic Pain - Characteristics

Symptom, defined by ICS as:

a: Duration of pain: Six months or more of persistent pain. b. Location of pain: Pelvis, lower abdomen, low back, medial aspect of thigh, inguinal area, perineum. c. Perception of pain: Patients may describe the pain as sharp, burning, aching, shooting, stabbing, pressure or discomfort, sexual pain (dyspareunia). d. Modality of pain: Persistent and/or continuous, recurrent and/or episodic and/or cyclic (related to menstrual cycle).

Purpose: Assessment/Diagnostic Info

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

https://www.ics.org/glossary/symptom/chronicpelvicpaincharacteristics?q=pelvic%20pain ,
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.37. Regions of persistent pelvic and associated pain - Other

Description: Other regions of persistent pain - Free text

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A

3.38. Persistent pelvic and associated pain occurs

Description: Provocatory activity causing pain: Unspecified

- When provoked
- During sexual intercourse
- During physical activities
- Spontaneously

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.39. Is surgical management planned to treat complication

Description: Indicator of whether surgical management planned to treat complication
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.40. Date of planned surgery

Description: The date upon which surgery planned to treat complication, expressed as DDMMYYYY.
Purpose: Surgical/procedural
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
N/A

3.41. Has the patient had a reoperation or will have a reoperation for a mesh exposure?

Description: Indicator of whether patient has had or having reoperation for mesh exposure - Yes / No
Purpose: Outcomes
Data Obligation: Mandatory
Data Collection: Entered by Hospital/Surgeon
Data Source, Standard / Terminology / Code set in use:
ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.42. Treatment for other complications since procedure

Description: Indicator of whether patient has had or having reoperation for non-mesh related complications - Yes / No

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

ACSQHC credentialing guidance relating to patient outcome monitoring and reporting

3.43. Describe surgical complication

Description: Description of surgical complication

Purpose: Outcomes

Data Obligation: Mandatory

Data Collection: Entered by Hospital/Surgeon

Data Source, Standard / Terminology / Code set in use:

N/A