



German Registry for Cardiac Operations and Interventions in Congenital Heart Disease: Annual Report 2022

Michael Hofbeck¹ Claudia Arenz² Ulrike M. M. Bauer³ Alexander Horke⁴ Gunter Kerst⁵
Renate Meyer⁶ Anja Tengler⁷ Andreas Beckmann⁸

¹ Department of Pediatric Cardiology, University Hospital Tuebingen, Tuebingen, Germany

² German Pediatric Heart Center, University of Bonn, Bonn, Germany

³ National Register for Congenital Heart Defects, Berlin, Germany

⁴ Division of Surgery for Congenital Heart Defects, Department of Cardiac Surgery, University of Hannover, Hannover, Germany

⁵ Clinic for Pediatric Cardiology and Congenital Heart Disease, Stuttgart, Germany

⁶ BQS Institute for Quality and Patient Safety, Hamburg, Germany

⁷ Division of Pediatric Cardiology and Pediatric Intensive Care, Ludwig Maximilian University of Munich, Munich, Germany

⁸ Clinic for Cardiac Surgery and Pediatric Cardiac Surgery Heart Center Duisburg, Duisburg, Germany

Address for correspondence Michael Hofbeck, MD, Department of Pediatric Cardiology, University Hospital Tuebingen, Tuebingen, Germany (e-mail: michael.hofbeck@uni-tuebingen.de).

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Abstract

Keywords

- ▶ congenital heart disease
- ▶ outcomes
- ▶ multicenter registry
- ▶ pediatric cardiology
- ▶ congenital heart surgery
- ▶ transcatheter intervention
- ▶ Fallot

Background The German Registry for Cardiac Operations and Interventions in Patients with Congenital Heart Disease is a voluntary registry initiated by the German Society for Thoracic and Cardiovascular Surgery and the German Society for Pediatric Cardiology and Congenital Heart Defects. Since 2012, the registry collects data for the assessment of treatment and outcomes of surgical and interventional procedures in patients with congenital heart disease (CHD) of all age groups.

Methods This real-world, prospective all-comers registry collects clinical and procedural characteristics, adverse events (AEs), mortality, and medium-term outcomes (up to 90 days) of patients undergoing surgical and interventional. A unique pseudonymous personal identifier (PID) allows longitudinal data acquisition in case of further invasive treatment in any participating German heart center. Prior to evaluation, all data sets are monitored for data completeness and integrity. Evaluation includes risk stratification of interventional and surgical procedures and classification of AEs. Each year's data are summarized in annual reports containing detailed information on the entire cohort, all subgroups, and 15 index procedures. In addition, each participating center receives an institutional benchmark report for comparison with the national results. This paper presents a comprehensive summary of the annual report 2021.

Results In 2021, a total of 5,439 patients were included by 22 participating centers. In total, 3,721 surgical, 3,413 interventional, and 34 hybrid procedures were performed

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during 6,122 hospital stays. 2,220 cases (36.3%) could be allocated to the 15 index procedures. The mean unadjusted in-hospital mortality ranged from 0.4% among interventional and 2% among surgical cases up to 6.2% in cases with multiple procedures. In-hospital mortality among index procedures accounted for 2.3% in total cavopulmonary connection, 20.3% in Norwood procedures, and 0.4% following interventional closure of patent ductus arteriosus. For the remaining seven surgical and five interventional index procedures, no in-hospital deaths were recorded. The 10-year longitudinal evaluation of 1,795 patients after tetralogy of Fallot repair revealed repeat interventional or surgical procedures in 21% of the patients. Over the same period, 31.1% of 2,037 patients, following initial treatment of native coarctation, required at least one additional hospital admission, 39.4% after initial interventional, and 21.3% after initial surgical therapy.

Conclusion The annual report 2021 of the German Registry for Cardiac Operations and Interventions in CHD shows continuously good results in accordance with previous data of the registry. Compared to international registries on CHD, it can be ascertained that in Germany invasive treatment of CHD is offered on a high medical level with excellent quality. The proven fact that patients with various malformations like tetralogy of Fallot and coarctation of the aorta require repeat procedures during follow-up confirms the urgent requirement for longitudinal assessment of all patients presenting with complex lesions.

Introduction

Treatment of congenital heart disease (CHD) is complex and carries a significant risk of morbidity. Therapeutic concepts frequently require several consecutive interventional and/or surgical procedures. Since the quality of care has a major impact on patients' long-term outcomes and quality of life, several scientific registries have been established worldwide during the recent decades to assess the outcome and to improve the quality of treatment.¹⁻⁹ At the beginning of this century, cardiac surgical procedures in CHD were subject to a nationwide obligatory external quality assurance in Germany. In 2004, this obligatory quality assurance measure, according to § 136ff Social Code Book V, was suspended by the political representatives (Bundeskuratorium) for various reasons. Based on the scientific awareness that surgical and interventional treatment of CHD patients represents complementary parts of common treatment concepts the German Society for Thoracic and Cardiovascular Surgery (DGTHG) and the German Society for Pediatric Cardiology and Congenital Heart Defects (DGPK) took the initiative and the responsibility to establish a prospective multicenter registry collecting data from German heart centers on interventional and surgical therapies in patients with CHD.^{10,11} The nationwide registry started in 2012. The purpose of this report is to provide a public comprehensive update based on the Annual Report of the German Quality Assurance for CHD 2022.

Materials and Methods

The voluntary German Registry for Quality Assurance in CHD (Nationale Qualitätssicherung Angeborene Herzfehler) is

designed to collect data on the treatment and outcome of patients suffering from CHD in Germany. The structure of the Registry and the data submission have been described in detail previously.^{10,11} The structures of the registry, data acquisition, and evaluation are in accordance with the guidelines of "Good Epidemiological Practice"¹², "Good Clinical Practice,"¹³ and the Declaration of Helsinki for medical research involving human subjects.¹⁴ The Registry has been approved by the Charité's Ethics Committee (code number: EA2/011/11).

Inclusion criteria are the presence of a congenital heart defect and performance of any cardiac surgical or transcatheter procedure. The inclusion of patients is based on the intention to treat rather than on success. Since treatment of CHD extends into adulthood, patients are included irrespective of their ages. Coding of diagnoses and procedures is performed by the International Pediatric and Congenital Cardiac Code (IPCCC).^{15,16}

Each included patient receives a unique personal identifier (PID) for the generation of a pseudonym. Based on this PID, any cardiac surgical or interventional procedure whenever performed in one of the participating German cardiac centers can be assigned to an individual patient. This enables longitudinal data acquisition as well as short- mid- and long-term evaluations.

Prior to evaluation the collected data are monitored with respect to data integrity and plausibility before case closure. Participation in this voluntary registry requires informed consent either of the patient or guardian, absence of consent being the only exclusion criterion.

Based on the initial treatment, all cases are allocated to one of four groups assorted by interventional, surgical,

multiple, or hybrid procedures. Interventional and surgical cases include all hospital admissions with an intention to treat the patient with a single procedure as well as those requiring subsequent additional treatment by a second or more procedures during the same admission due to an unpredicted complication. The group “multiple procedures” summarizes all patients with a predefined treatment concept, which consists of at least two procedures during one admission (e.g., arterial switch operation following balloon atrioseptostomy). Hybrid procedures are defined as combined surgical and interventional one-stage procedures. For risk stratification, the interventional cases are assigned to risk categories 1 to 4 according to the Catheterization for Congenital Heart Disease Adjustment for Risk Method,² while surgical cases are assigned to risk categories 1 to 5 according to the Society of Thoracic Surgeons (STS)—European Association for Cardio-Thoracic Surgery (EACTS) mortality categories.¹ Risk stratification of the two remaining groups (multiple and hybrid procedures) is not possible yet due to the lack of established risk categories for these treatment options.

Evaluation of the four groups includes analysis of procedure-related data as well as analysis of various indicators, including adverse events (AEs), in-hospital mortality, 30- and 90-day mortality. Major AEs following surgical procedures are classified according to the STS morbidity classification codes in the STS Congenital Heart Surgery Database Data collection form, Version 2.50 as cited in Jacobs et al.¹⁷ AEs following interventional procedures are categorized in five categories according to Bergersen et al.² To allow a detailed and differentiated view on specific procedures in homogeneous subgroups of CHD, 15 index procedures (nine surgical and six interventional) were defined. The surgical procedures include atrial septal defect (ASD) and ventricular septal defect (VSD) closure, repair of atrioventricular septal defect (AVSD), repair of aortic coarctation (COA), arterial switch operation for transposition of the great arteries (TGA) with intact ventricular septum, repair of tetralogy of Fallot (TOF), total cavopulmonary connection (TCPC), Norwood procedure, and pulmonary valve replacement (PVR). Interventional procedures include ASD and VSD closure, treatment of aortic COA and reoarctation (ReCOA), closure of patent ductus arteriosus (PDA) and percutaneous pulmonary valve implantation (PPVI).

Longitudinal evaluation was performed for all patients following surgical TOF repair and for all patients who received surgical or interventional treatment of native COA from 2012 until 2021. These patients were analyzed for subsequent invasive treatment during the follow-up.

Results

In 2021, a total number of 22 German centers contributed 6,122 cases (hospital stays) under the terms of quality assurance. Numbers of patients, cases, and procedures, documented in the registry in 2021, are shown in ►Table 1. Detailed data from 2,810 surgical cases and 356 cases with multiple procedures were provided by 18 centers, accounting for a total of

Table 1 Patients, cases, and procedures in 2021

Patients	5,439	89.85%	1 hospital stay
		10.15%	≥ 2 hospital stay
Cases	6,122	90.38%	Single procedure
		9.62%	≥ 2 procedures
Procedures	7,168	3,721	Surgical
		3,413	Interventional
		34	Hybrid

3,721 surgical procedures. In total, 23 departments submitted data from 2,931 interventional cases resulting in a total of 3,413 interventional procedures, while hybrid procedures accounted for only 25 (0.4%) of the reported cases including 34 procedures. In 10.1% of the patients included in 2021, more than one hospital stay for interventional or surgical treatment was recorded.

According to the data of the German Heart Foundation, published in the German Cardiac Report (Deutscher Herzbericht 2022, www.herzstiftung.de),¹⁸ the German Registry represents 72% of institutions performing surgical and 92% of institutions performing interventional treatment of CHD. The 3,721 surgical procedures included in the German Registry represent 67.2% of operations for CHD reported in the German Heart Surgery Report 2021, which is based on a voluntary public report of 78 German heart surgery departments.¹⁹ The 3,413 interventional procedures of the German Registry represent 73% of the procedures from 24 institutions listed in the German Cardiac Report (Deutscher Herzbericht 2022).¹⁸

Age and Gender Distribution

Almost 36% of cases were performed in newborns and infants, and 50% of the cases in children and adolescents. Treatment in adults with CHD accounted for 14.5% of cases (►Table 2). The age distributions as well as the predominance of the male gender remained nearly unchanged compared to previous years.

Key Performance Indicators

Details for interventional and surgical cases as well as for the index procedures are summarized in ►Tables 2, 3, and 4. In total, 56.4% of the interventional cases were performed in patients who had previously undergone either surgical

Table 2 Age and gender distribution in 2021

	Cases	%
Newborns	694	11.3
Infants	1,481	24.2
Children and adolescents	3,060	50
Adults	887	14.5
Males	3,307	54
Females	2,815	46

Table 3 Interventional cases: key performance indicators

	Centers	Cases	Age (years) ^a	Hospital stay (d) ^a	ICU stay (%)	GA (%)	Fluoroscopy (%)	Fluoroscopy time (min) ^a
Interventions	23	2,931		2.0 (2.0/3.0)	14.2	17.4	95.3	11.0 (5.9/19.5)
ASD	22	442	9.1 (5.4/38.3)	2.0 (2.0/3.0)	6.1	29.9	82.8	4.2 (2.4/7.5)
VSD	13	35	6.3 (2.3/11.3)	3.0 (2.0/3.0)	8.6	20.0	97.1	16.9 (10.0/26.5)
COA	15	61	4.1 (0.2/11.1)	3.0 (2.0/7.0)	37.7	27.9	100	6.2 (4.0/9.2)
ReCOA	12	23	16.8 (10.1/24.0)	2.0 (2.0/3.0)	26.1	0	100	9.6 (3.2/12.0)
PDA	22	274	1.9 (0.6/4.3)	2.0 (2.0/3.0)	16.4	8.8	100	7.0 (4.4/11.4)
PPVI	15	101	17.8 (14/30.3)	5.0 (4.0/6.0)	16.8	51.5	100	24.4 (16.4/38.3)

Abbreviations: ASD, atrial septal defect; COA, coarctation; GA, general anesthesia; ICU, intensive care unit; PDA, patent ductus arteriosus; PPVI, percutaneous pulmonary valve implantation; ReCOA, reocclusion; VSD, ventricular septal defect.

^aNumbers represent median and standard deviation.

Table 4 Surgical cases: key performance indicators

	Centers	Cases	Age (years) ^a	Hospital stay (d) ^a	ICU stay (d) ^a	Ventilation period (h) ^a	CPB (%)	Perfusion time (min) ^a	Gross-clamp (%)
Surgical procedures	18	2,810		11 (8/17)	4 (2/8)	8 (5/30)	74.8	113 (76/167)	59.1
ASD	18	172	4.0 (2.4/6.0)	8 (6/9)	2 (2/3)	5 (3/7)	100	51 (33/66)	70.9
VSD	17	233	0.4 (0.3/0.8)	9 (8/12)	4 (2/6)	8 (5/50)	100	93 (77/121)	100
AVSD	17	172	0.5 (0.4/2.0)	12 (8/16)	6 (3/9)	12 (6/97.5)	100	137 (102/182)	98.3
COA	14	119	0.0 (0.0/0.1)	11(7/17)	4 (3/7)	13 (6/50)	28.6	80 (55/109)	26.1
TGA	18	73	0.0 (0.0/0.0)	21 (18/28)	10 (8/14)	51.5 (8/138)	100	155 (134/209)	100
TOF repair	18	163	0.5 (0.4/0.7)	12 (9/18)	5 (3/8)	11 (7/78)	100	136 (106/169)	100
TCPC	16	174	3.8 (3.1/4.4)	16.5 (13/24)	5 (3/10)	7 (5/11)	100	96 (65/124)	19
Norwood	14	79	7 (5/9) ^b	45 (34/92)	28.5 (14/50)	127 (48/221)	100	210 (162/267)	100
PVR	15	99	17.9 (8.5/30.5)	9 (8/13)	3 (2/5)	8 (6/11)	99	143 (99/182)	38.4

Abbreviations: ASD, atrial septal defect; AVSD, atrioventricular septal defect; COA, coarctation; CPB, cardiopulmonary bypass; ICU, intensive care unit; PVR, pulmonary valve replacement; TCPC, total cavopulmonary connection; TGA, transposition of the great arteries; TOF, tetralogy of Fallot; VSD, ventricular septal defect.

^aNumbers represent median and standard deviation.

^bIn patients with the Norwood procedure, the median and standard deviation of age are given in days.

(12.1%) or interventional treatment (7.4%) or a combination of both (36.9%). The median hospital stay of interventional cases was 2 days, and intensive care unit stay was required in 14.2% only (►Table 3). In the majority of cases (82.5%), the procedure was performed under analgesedation without the requirement of general anesthesia and mechanical ventilation. It was noticeable that 4.7% of the cases were performed without fluoroscopy (mainly ASD closures and balloon-atrio-septostomies in TGA). The analysis of interventional index procedures revealed significant differences among the different procedures partially related to the complexity of the procedure and partially associated with the age group requiring the specific treatment. ASD closure was the most frequent intervention (442 cases) among the index procedures, 24.7% of these procedures were performed for closure of PFO. General anesthesia was required in 29.9%, fluoroscopy was avoided in 17.2% of these cases (►Table 3). The most laborious interventional index procedure was PPVI, which was performed under general anesthesia in 51.5% of the cases. Almost half of the procedures were performed in adults (47.5%). Median procedure time (160 minutes) and median fluoroscopy time (24.4 minutes) exceeded all other procedures (►Table 3).

Due to the different nature of the treatment, surgical cases required more resources. Intensive care treatment was required in 93.5% of the cases with a median length of

stay in the intensive care unit (ICU) of 4 days and in the hospital of 11 days (►Table 4). Preceding interventional (5.7%), surgical (20.2%), or combined invasive treatment (18.4%) was common accounting for 44.3% of surgical cases. In total, 74.8% of the procedures were performed under cardiopulmonary bypass conditions, and in 54.4% of the cases, blood transfusions were required (►Table 4). VSD closure (233 cases) was the most frequent surgical index procedure followed by TCPC (174 cases), ASD and AVSD closure (172 cases each), and TOF repair (163 cases). The surgical treatment appeared highly standardized with narrow interquartile ranges for perfusion and aortic cross-clamp times as well as for the duration of hospital stay. There were only minor differences in these parameters as compared to previous years.

The complex nature of univentricular heart treatment was apparent in the evaluation of Norwood operation and TCPC cases. The predominant diagnosis in Norwood cases was hypoplastic left heart syndrome (HLHS) with 78.5%. Fourteen patients (18%) received bilateral pulmonary arterial banding prior to the Norwood procedure. Norwood patients had the longest perfusion times (median 210 minutes), longest mechanical ventilation (median 127 hours), longest ICU stay (median 28.5 days), and longest in-hospital stay (median 45 days) (►Table 4). Twenty percent of the patients required one

Table 5 Cases and index procedures: In-hospital mortality and freedom from adverse events

	Mortality/Cases	%	Freedom from AE/cases	%
Cases: Total	90/6,122	1.5	4,786/6,122	78.2
Interventional cases	12/2,931	0.4	2,730/2,931	93.1
Surgical cases	55/2,810	2	1,897/2,810	67.5
Multiple procedure cases	22/356	6.2	142/356	39.9
Interventional index procedures				
ASD	0/442	0	423/442	95.7
VSD	0/35	0	29/35	82.9
COA	0/61	0	54/61	88.5
ReCOA	0/23	0	23/23	100
PDA	1/274	0.4	261/274	95.3
PPVI	0/101	0	88/101	87.1
Surgical index procedures				
ASD	0/172	0	159/172	92.4
VSD	0/233	0	191/233	82
AVSD	0/172	0	110/172	64
COA	0/119	0	87/119	73.1
TGA	0/73	0	31/73	42.5
TOF repair	0/163	0	90/163	55.2
TCPC	4/174	2.3	85/174	48.9
Norwood (<90 d)	16/79	20.3	13/79	16.5
PVR	0/99	0	78/99	78.8

Abbreviations: AE, adverse events; ASD, atrial septal defect; AVSD, atrioventricular septal defect; COA, coarctation; PDA, patent ductus arteriosus; PPVI, percutaneous pulmonary valve implantation; PVR, pulmonary valve replacement; ReCOA, recoarctation; TCPC, total cavopulmonary connection; TGA, transposition of the great arteries; TOF, tetralogy of Fallot; VSD, ventricular septal defect.

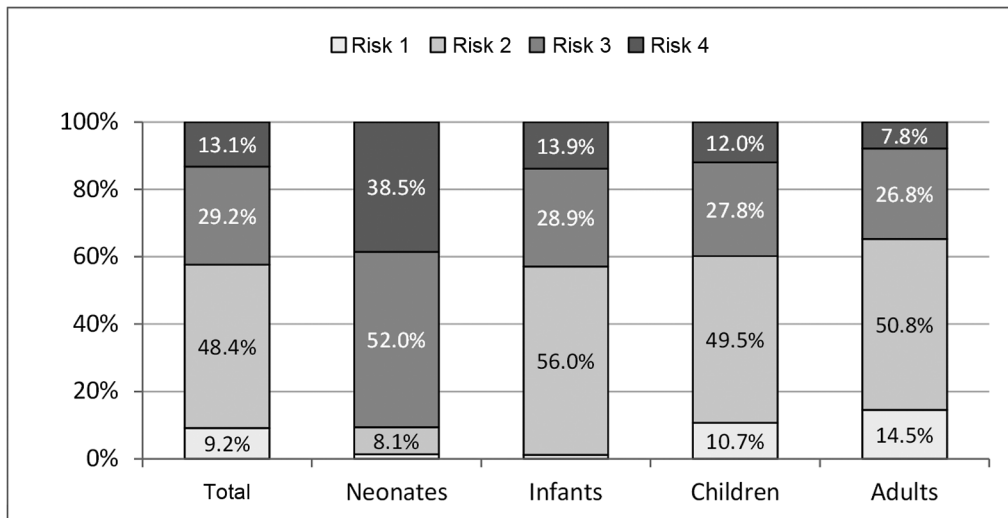


Fig. 1 Interventional cases: risk diversification in different age groups according to the Bergersen risk score.²

and forty-four percent required two or more subsequent interventional or surgical procedures during the same hospital stay. In 2021, 14/18 units participating in this registry entered data on Norwood procedures. Concerning the index procedure, TCPC HLHS was also the most frequent main diagnosis (36.8%), followed by tricuspid atresia (16.1%). Bidirectional superior cavopulmonary anastomosis was the most frequent preceding palliative procedure (79.3%). Extracardiac conduit from inferior caval vein to the pulmonary artery without (58%) or with fenestration (28.2%) was the predominant surgical technique. TCPC cases showed short ventilation periods with a small interquartile range (median 7 hours), but relatively long and variable lengths of hospital stay (median 16.5 days) (►Table 4).

Key Quality Indicators

The in-hospital mortality during 2021 (2.0% in surgical and 0.4% in interventional cases) is specified in ►Table 5. Cases

with multiple procedures carried a higher mortality rate of 6.2%.

Seventy-five percent in-hospital deaths in interventional cases occurred in neonates and infants. Risk stratification according to the Catheterization for Congenital Heart Disease Adjustment for Risk Method² was possible in 89.1% of interventional cases. Analysis of the different age groups revealed that in neonates a higher percentage of procedures belonged to risk categories 3 or 4 (90.5%) as compared to infants (42.8%), children/adolescents (39.8%), or adults (34.7%) (►Fig. 1). AEs were noted in 6.9% of interventional cases (►Table 5). Irrespective of the age group, the highest rate of AE was recorded among patients of the highest risk categories (►Fig. 2). Due to the predominance of procedures in the higher risk categories the largest percentage of AE (13.9%) was recorded in the neonatal age group. Seventy-three percent of AE resulted in minor or transient harm to the patients, while twenty-three percent were categorized as

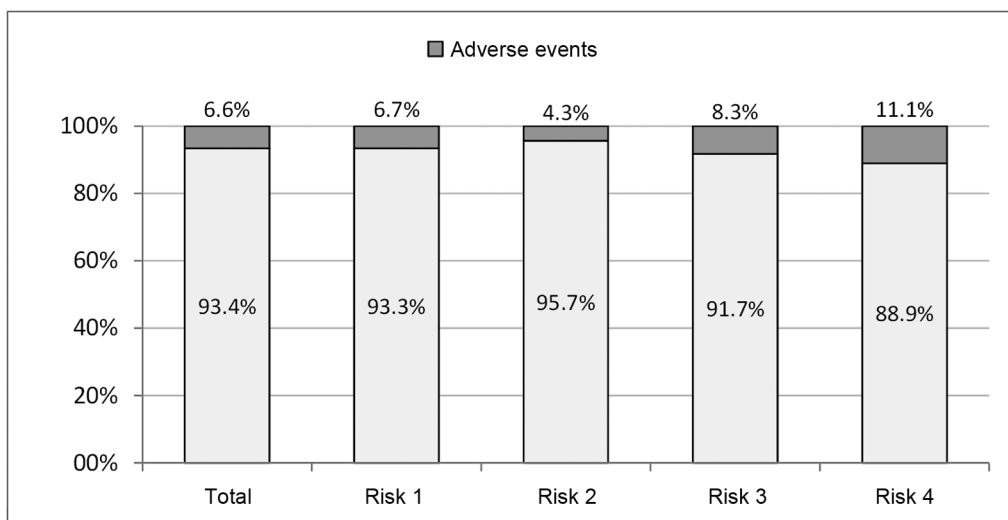


Fig. 2 Interventional cases: association of Bergersen risk score categories² and adverse events.

Table 6 Interventional cases: comparison of major AE (severity level 4 and 5 according to Bergersen et al.²) in the German Registry with AE rates (performance data set 05/2008–12/2009) of the 3CPO project²

Adverse events	German Registry AE/patients	German Registry AE rate (%)	CCCPO data set (5/2008–12/2009) AE/patients	CCCPO data set (5/2008–12/2009) AE rate (%)
Any AE	201/2,931	6.9	858/7,043	12.2
AE level 4 and 5	47/2,931	1.6	99/7,043	1.4

Abbreviation: AE, adverse events.

Table 7 Interventional cases: comparison of adverse events (AE) in the German Registry according to procedure-type risk categories² with AE rates (performance data set May 2008–December 2009) of the 3CPO project²

Risk categories	AE/cases	German Registry Rate of AE (%)	3CPO Registry Rate of AE (%)
Category 1	16/240	6.7	5.2
Category 2	55/1,265	4.3	13
Category 3	63/763	8.3	19
Category 4	38/343	11.1	25

major or catastrophic occurring in 1.6% of all interventional cases (►Table 6). No categorization was available yet in 4% of AEs. ►Table 7 presents a comparison of observed AEs with data from the Congenital Cardiac Catheterization Project on Outcomes (C3PO) registry,² while a comparison of major AEs² including the categories “major” and “catastrophic” is given in ►Table 6.

No in-hospital mortality was noted among patients with interventional index procedures except for 1/274 patients (0.4%) following interventional closure of PDA (►Table 5). Freedom of AEs > 95% was reported in cases of interventional closure of ASD and ductus arteriosus as well as treatment of ReCOA (►Table 5). Freedom of AEs was lower for interventional treatment of native COA (88.5%), PPVI (87.1%), and during interventional VSD closure (82.9%).

Classification of complexity according to the risk categories of the Society of Thoracic Surgeons-European Association for Cardio-Thoracic Surgery (STS-EACTS) mortality score¹ was possible in 91.9% of the cases. In-hospital mortality correlated with the level of complexity ranging from 0.5% in category 1 up to 18.9% in category 5 (►Table 8). Procedures of the risk categories 4 and 5 were prevalent in the neonatal age group (50.7.6%) as compared to their proportion among

infants (14.9%), children/adolescents (7.5%), or adults (7.8%) (►Fig. 3 and 4). Due to the predominance of higher risk operations, the in-hospital mortality was higher in neonates (7.8%) as compared to infants (1%), children and adolescents (1%), or adults (1.4%).

In the subgroup analysis of surgical index procedures, the in-hospital mortality following the Norwood (20.3%) procedure was remarkable but similar to previous years (2020: 18.7% and 2019: 19.8%). The in-hospital mortality rate following TCPC was 2.3%, while no mortality was noticed among patients undergoing one of the remaining seven surgical index procedures (►Table 5). A comparison of in-hospital mortality rates among five index procedures matching index procedures from the European Congenital Heart Surgeons Association (ECHSA) database²⁰ is provided in ►Table 9.

AEs were recorded in 32.5% of surgical cases (►Table 5). Their frequency correlated with the complexity according to the risk categories of the STS-EACTS mortality score ranging from 19.2% in category 1 to 87.8% in category 5. Procedures of higher risk categories were prevalent in the neonatal age group (►Fig. 3). Comparison of AEs in the German Registry with data in the literature has to take into consideration that

Table 8 Surgical cases: comparison of in-hospital mortality in the German registry according to STS-EACTS mortality risk categories¹ with mortality rates (2002–2007) according to O'Brien et al¹

STS-EACTS mortality risk category ¹	German Registry Mortality/patients	German Registry Mortality rate (%)	STS-EACTS ¹ mortality rate 2002–2007 (%)
Category 1	5/1,083	0.5	0.8
Category 2	17/735	2.3	2.6
Category 3	7/342	2.0	5.0
Category 4	10/349	2.9	9.9
Category 5	14/74	18.9	23.1

Abbreviation: STS-EACTS, Society of Thoracic Surgeons-European Association for Cardio-Thoracic Surgery.

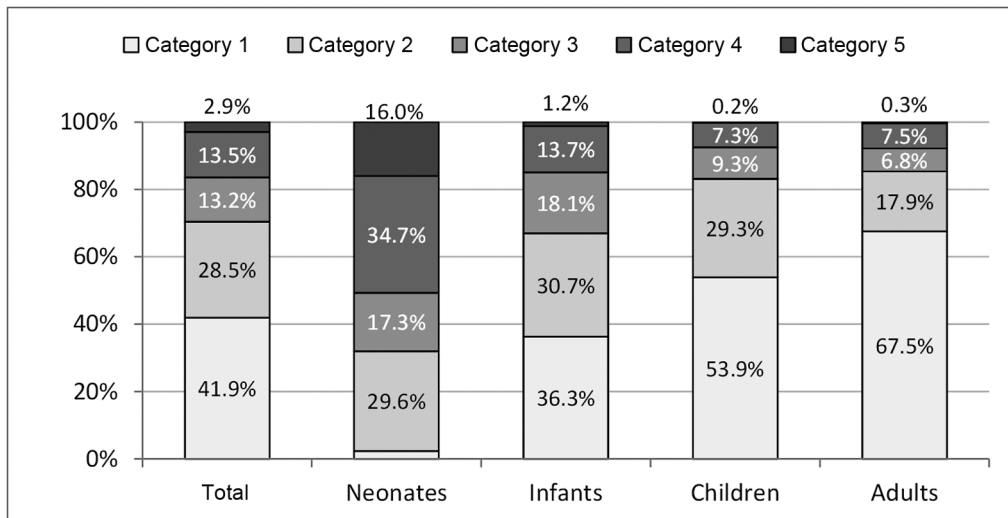


Fig. 3 Surgical cases: risk diversification according to STAT mortality categories¹ in different age groups.

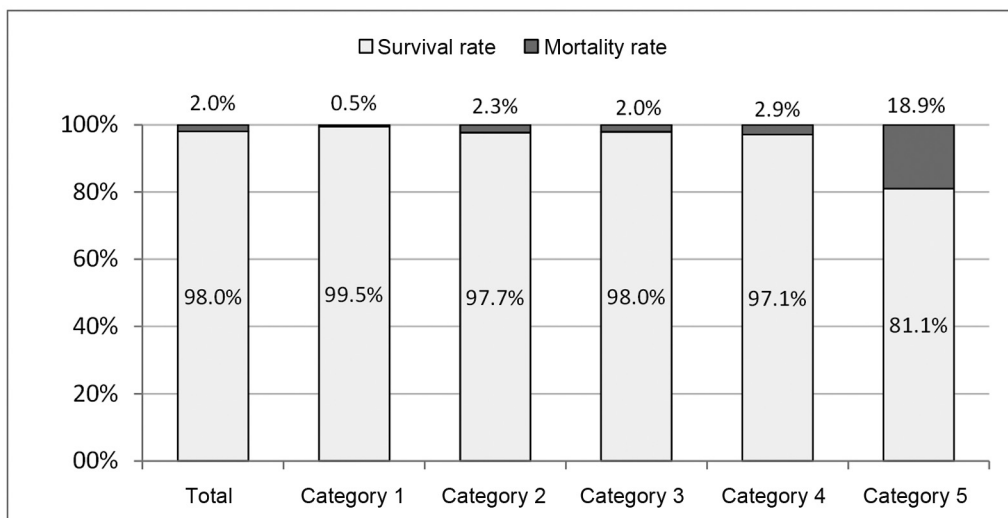


Fig. 4 Surgical cases: association of STAT mortality categories¹ and in-hospital mortality.

many registries are reporting major AEs only.^{17,21} The reporting of the German Registry also includes minor AEs (67.4%), while 31.2% were classified as major complications according to Jacobs et al.¹⁷

AEs among the surgical index procedures were < 30% after ASD and VSD closure, PVR, and treatment of native COA (→ **Table 5**). Values between 30 and 60% were recorded in patients following AVSD repair, TOF repair, TCPC, and arterial

Table 9 Surgical index cases: comparison of in-hospital mortality in the German registry with ECHSA database data according to Bertsimas et al.²⁰

Index procedures	German Registry cases 2021	Mortality 2021 (%)	German Registry cases 2017–2021	Mortality 2017–2021 (%)	ECHSA database cases 2016–2019	ECHSA database mortality 2016–2021 (%)
VSD	233	0	1,326	0	2,503	0.6
TOF repair	163	0	865	0.6	249	1.2
TGA	73	0	430	1.4	757	5.4
TCPC	174	2.3%	797	1.0	420	2.9
Norwood	79	20.3%	332	19.6	564	28.4

Abbreviations: ECHSA, European Congenital Heart Surgeons Association; TCPC, total cavopulmonary connection; TGA, transposition of the great arteries; TOF, tetralogy of Fallot; VSD, ventricular septal defect.

switch operation for TGA. As expected patients after Norwood procedures showed the highest AE rate (83.5%) (►Table 5).

The case volume in the category multiple procedures was significantly smaller (356) than in isolated surgical or interventional cases (►Table 5). Although there is presently no risk categorization for these combinations of treatment, the fact that the majority of cases in this group were treated in the first year of life (44.9% newborns and 23.9% infants) suggests that these treatment concepts are performed preferentially in high-risk patients with complex CHD. In total, 71.9% underwent one subsequent and 28.1% required two or more subsequent procedures accounting for a total of 563 procedures (347 operations and 216 interventions). The complexity of this group is also evident in the in-hospital mortality rate of 6.2% and a rate of cases without AEs of 39.9% (►Table 5).

Longitudinal Observations Tetralogy of Fallot

The database included 1,795 patients following TOF repair during the 10-year period from 2012 to 2021. Palliative procedures prior to surgical repair were performed in 17.9% of the patients (►Fig. 5). These palliative procedures included interventional (53.6%) and surgical procedures (33.3%) or a combination of both (13.1%). Following surgical repair, repeat procedures were recorded in 373 patients (21%). They were less common among patients undergoing primary repair (17%) as compared to patients with preceding palliative procedures (38%). The largest number of repeat procedures was recorded during the first year after repair: 141/1,781 patients (7.9%) required at least one additional

hospital admission (►Fig. 6). This number decreased continuously during the subsequent years resulting in 1.3% of the patients requiring repeat interventional or surgical treatment in the tenth postprocedural year.

Longitudinal Observations Coarctation of the Aorta

From 2012 to 2021, the registry recorded 2,037 patients following primary treatment of native COA. In total, 883 patients (43.3%) were newborns, 522 infants (25.6%), 500 children and adolescents (24.5%), and 132 were adults (6.5%). Initial treatment was performed by transcatheter intervention in 30.3% and by surgery in 69.7% of the patients (►Fig. 7). With respect to patients' age, there was a clear dominance of surgical strategies in the primary treatment of neonates (89.8%) and infants (82.2%), while interventional procedures dominated the treatment in children and adolescents (63.2%) as well as in adulthood (89.4%). Among patients who underwent interventions, balloon dilatation was the preferred method in infants (81.7%), while stent implantation was the dominant procedure in children/adolescents (68.4%) and especially in adults (96.6%). Notably, there was also a significant percentage of stent implantations (51.1%) among interventions in the neonatal period. The majority of surgical treatments (86%) was performed in the 1st year of life. Extracorporeal circulation was required in 24.7% of the surgical procedures.

Repeat procedures requiring further hospital admissions were noted in 39.4% of patients with initial interventional and in 21.3% of patients who underwent primary surgical treatment. The requirement of hospital readmissions was highest in the 1st year of treatment (20.7%) and decreased

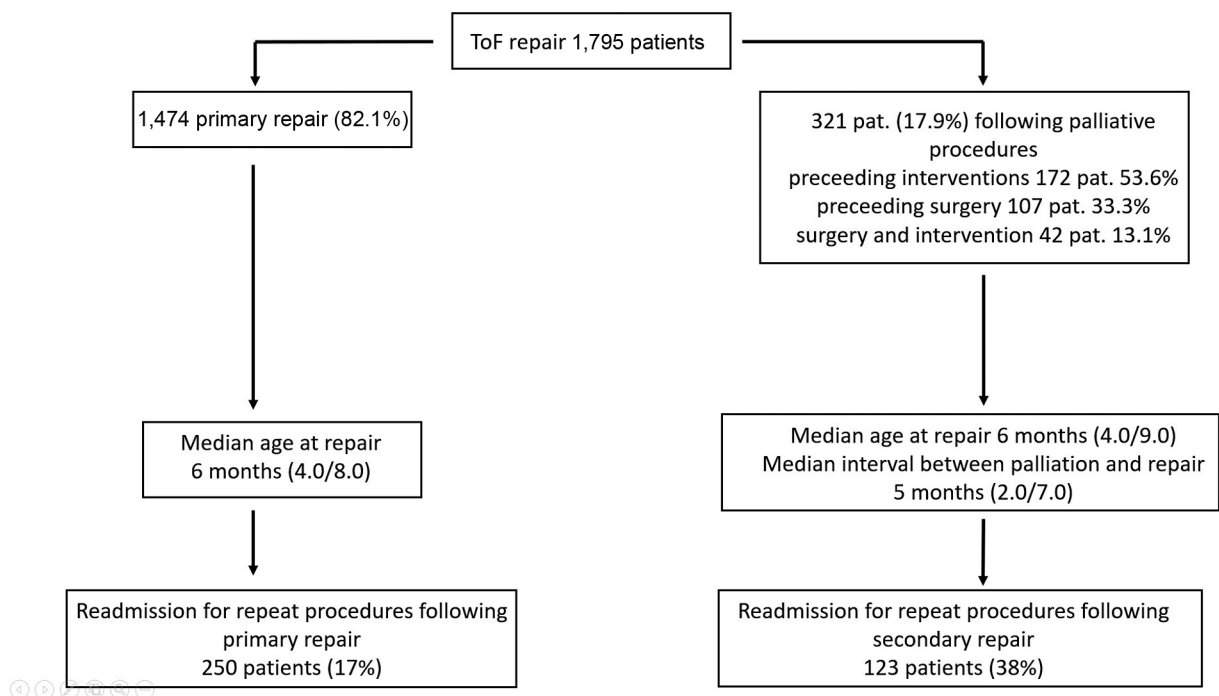


Fig. 5 Surgical repair in TOF from 2012 to 2021. Comparison of readmissions for repeat procedures in patients following primary and secondary repair.

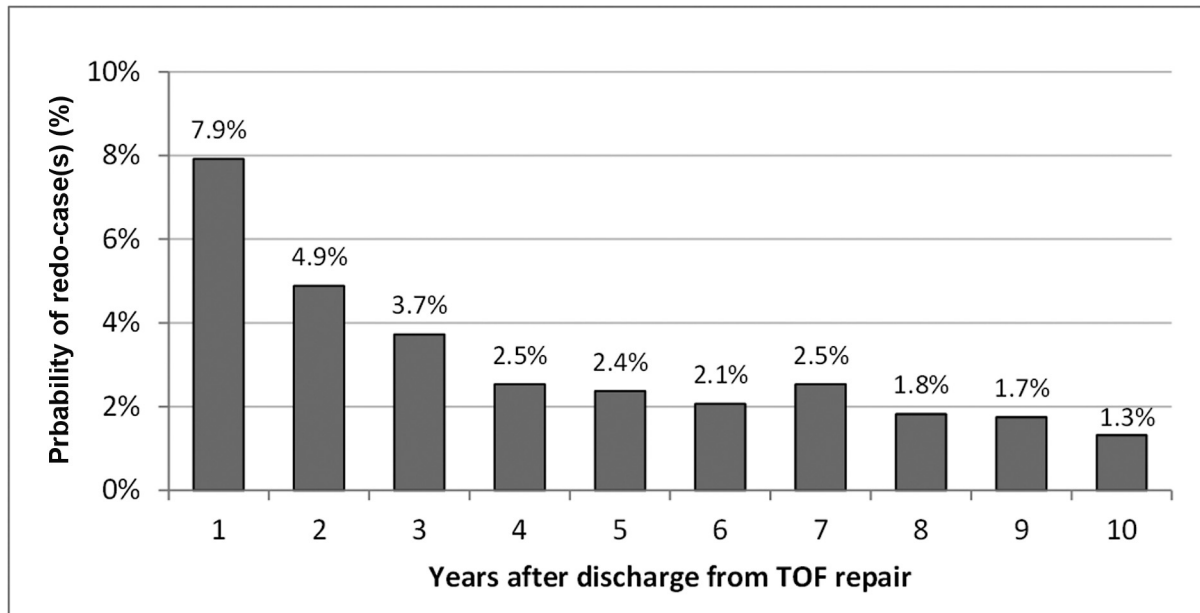


Fig. 6 Proportion of patients following TOF repair requiring repeat hospital admission for surgical or interventional treatment. The probability refers to the total number of patients during the respective time interval. Since no data are available on the completeness of follow-up, the probability may be underestimated and requires interpretation as a minimum proportion.

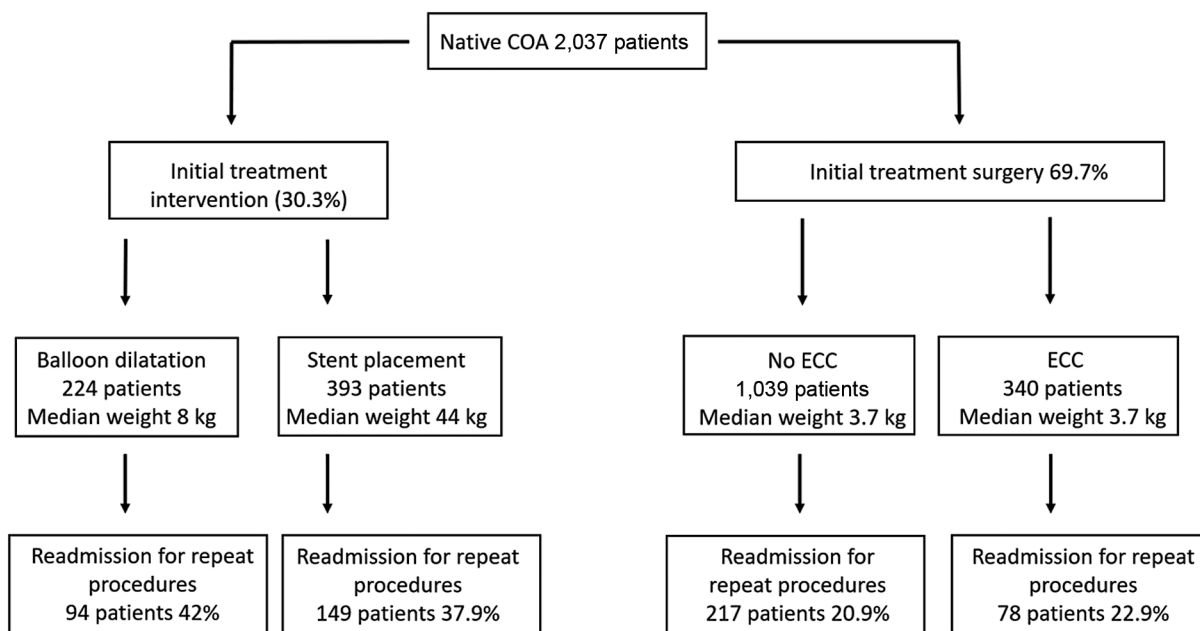


Fig. 7 Treatment of patients with native COA from 2012 to 2021. Comparison of readmissions for repeat procedures following initial interventional or surgical treatment.

significantly in the 3rd year to a level < 3%. However, this rate of 2 to 3% remained quite constant during the following years (► Fig. 8).

Discussion

Since 2012, the German Registry for Cardiac Operations and Interventions in patients with CHD collects data on interventional and surgical treatment from the neonatal age until

adulthood.^{10,11} So far, these data cover an entire decade describing the results of current invasive treatment in these complex patients in Germany. The data of each year were summarized in annual reports containing detailed age and risk-related outcome data on key quality indicators for all different case groups and for 15 index procedures (www.dgpk.org, www.dgthg.org). In addition, all participating institutions received a specific center-related report allowing a benchmark of the institutional performance to the

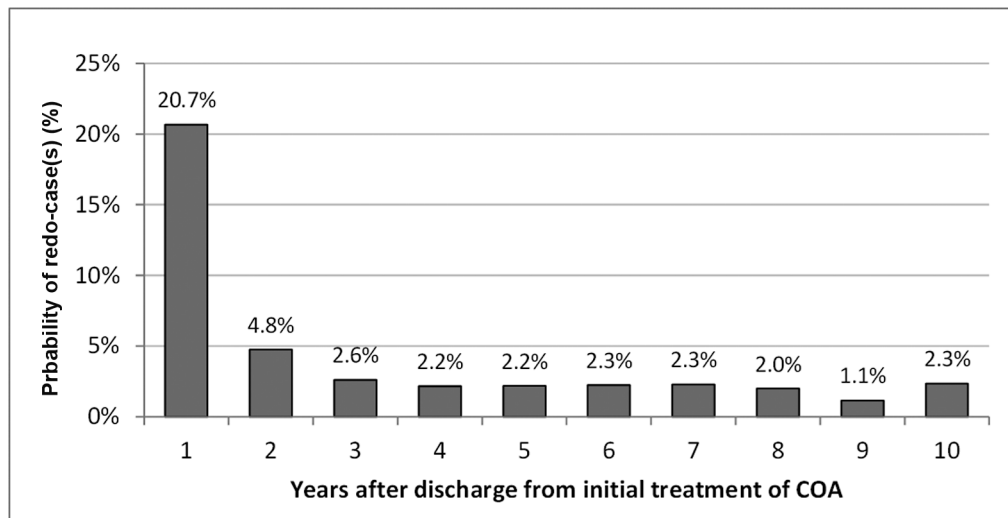


Fig. 8 Proportion of patients following primary treatment of native COA requiring repeat hospital admission for surgical or interventional treatment. The probability refers to the total number of patients during the respective time interval. Since no data are available on the completeness of follow-up, the probability may be underestimated and requires interpretation as a minimum proportion.

national cohort. The underlying paper presents a comprehensive summary of the Annual report 2022 of the German Quality assurance for CHD. It has to be mentioned that some selected data from the German Registry have already been included in the German Heart Report 2022 (Deutscher Herzbericht).¹⁸

Like in previous years, the data of this registry reflect the complexity of CHD and the complementary nature of interventional and surgical procedures: 56.4% of interventional cases were performed in patients following prior hospital admissions for surgical and/or interventional treatment, while preceding procedures were also recorded in 44.3% of the surgical cases. 10.1% of the patients required more than one hospital treatment in 2021.

The overall in-hospital mortality of surgical cases (2.0%) was slightly higher than in 2020 (1.6%) but remained within the average mortality of previous years (1.4–2.6%) in the German Registry.^{10,11} The observed mortality rates correlated with the level of complexity according to the risk categories of the STS-EACTS mortality score.¹ Comparison of the surgical mortality in the German Registry 2021 and the expected in-hospital mortality according to the STS-EACTS database¹ revealed excellent results over the entire range of mortality categories (► **Table 8**). This applies as well for data concerning the surgical index procedures VSD closure, TOF repair, arterial switch operation in TGA, TCPC, and Norwood procedure. Both the mortality in the German Registry in 2021 and the average mortality over the last 5 years compare favorably to the data from the ECHSA database (► **Table 9**) published in 2022.²⁰

Cases with multiple procedures carried a significantly higher in-hospital mortality of 6.2% reflecting the complex nature of these patients, who were predominantly treated either in the neonatal age or in infancy (68.8%). The mortality rate was similar compared to 2020¹¹ and lower than the average mortality of multiple cases (6.2–10.4%) observed from 2015 to 2019.¹⁰

In-hospital mortality among interventional cases (0.4%) was similar compared to data from the German Registry from previous years (0.2–0.8%).^{10,11} It did not play a significant role among interventional cases, although 42.4% of the cases in 2021 belonged to the risk categories 3 and 4. The frequency of observed AEs was in the expected range (► **Tables 6 and 7**) or below as compared to data published by the CCCPO registry.²

The structure of the German Registry provides the possibility of longitudinal assessment since readmissions for repeat interventional or surgical treatment can be assigned by the PID, even if the treatment is provided by different centers. Therefore, this report also includes data on 10 years' longitudinal evaluation of TOF patients following corrective surgery and patients following the treatment of native COA. Evaluation of children with TOF revealed two groups of patients: while the majority of patients underwent primary surgical repair (82.1%), a smaller group of patients required prior palliative procedures (17.9%). Among these palliative procedures, interventions have gained a significant share either as exclusive interventional palliations (53.6%) or as combinations of interventional and surgical palliative procedures (13.1%) confirming trends reported in the international literature.²² After surgical repair, repeat procedures were required less frequently among patients following primary repair (17%) as compared to patients who underwent preceding palliation (38%). In our opinion, this can be explained by the fact that the latter group represents patients with a less favorable anatomic spectrum regarding the morphology of the right ventricular outflow tract and the central pulmonary arteries. This is supported by the fact that 70% of repeat interventional procedures addressed problems of the central pulmonary arteries (61%) or the right ventricular outflow tract (9%). Similar data have been reported in the literature.²³ The annual report 2021 recorded no mortality following TOF repair. This is in accordance with the results of previous years and compares very favorably with data reported from the ECHSA database in 2022 (► **Table 9**).²⁰

Longitudinal analysis of patients who underwent treatment of native COA revealed significant differences depending on the patients' age, which are certainly also influenced by the underlying morphology of the obstruction. While surgical strategies dominated the primary treatment in neonates and infants, interventional methods were the preferred treatment in children and adolescents as well as in adults (► **Fig. 7**). The significant number of repeat procedures especially in the first year after initial treatment (20.7%) confirms the complex nature of this cardiovascular malformation (► **Fig. 8**).

Future Perspectives

The data sets covering surgical and interventional procedures are compatible with the ECHSA database to provide the possibility of future data transfer/migration and international compatibility. STAS mortality categories and Bergersen risk categories as well as AEs scores will be adjusted according to recent updates to allow continuous comparison with other databases.^{7,20,21,24–26} Demands on biocompatibility and longevity are particularly important for medical devices implanted in neonates, children, and adolescents for the treatment of CHD.^{27,28} To meet the future requirements of an obligatory implant registry, the German database started in 2023 to include specific details for ASD- and PDA-occluders as well as PPVI. Implementation of defined surgical devices is provided for 2024.

Limitations

The registry is limited by its all-comers registry design and the voluntary participation of patients and institutions. Financial restrictions are due to the fact that presently the registry does not receive public funding. Financial support for the registry is provided exclusively by the participating centers, the DGTHG and the DGPK. Comparisons of in-hospital mortality and AEs of the German Registry with results of the STS-EACTS database and the CCCPO registry have to take into consideration that these data were obtained in different time periods.

Collaborators

German Quality Assurance/Competence Network for Congenital Heart Defects

Ulrike Herberg, Majed Kanaan, Corinna Lebherz, Stefan Ostermayer, André Rüffer, Mustafa Gülgün, Vincent Kundt, Thai Duy Nguyen (Aachen); Stephan Schubert, Kai Thorsten Laser, Eugen Sandica, Alexey Ilin, Alina Georgiana Sandica, Marek Zubrzycki, Ursula Schultz-Kaizler, Yasin Essa (Bad Oeynhausen); Felix Berger, Oliver Miera, Bernd Opgen-Rhein, Joachim Photiadis (Berlin); Johannes Breuer, Martin Schneider, Nicole Müller, Boulos Asfour, Benjamin Bierbach, Lennart Dübener, Mathieu Vergnat (Bonn); Gleb Tarusinov, Aktham Tannous, Christina Rogkakou, Paul Hacke, Jochen Börgermann, Michael Scheid, Andrey Semyashkin (Duisburg); Sven Dittrich, Wolfgang Wällisch, Oliver Dewald,

Ariawan Purbojo, Johannes Rösch, Michela Cuomo, Saya Aziz (Erlangen); Brigitte Stiller, Alexej Bobrowski, Charlotte Schwab, Christoph Zürn, Daniela Kocher, Hannah Kappler, Hendryk Schneider, Lisa Marie Stelling - Fuchs, Meike Schwendt, Miriam Schwab, Simon Oberle, Thilo Fleck, Martin Czerny, Fabian Alexander Kari, Fatos Ballazhi, Johannes Kroll, Matthias Siepe (Freiburg); Christian Jux, Hakan Akintürk, Klaus Valeske (Gießen); Thomas Paul, Matthias Sigler, Heike Schneider, Matthias Müller, Ulrich Johannes Krause (Göttingen); Rainer Kozlik-Feldmann, Carsten Rickers, Lena Christine Siebel, Philipp Schneider, Roland Volker Jebens, Veronika Stark, Michael Hübler, Daniel Biermann, Jörg Sachweh (Hamburg); Philipp Beerbaum, Dietmar Böthig, Arjang Ruhparwar, Dmitry Bobylev, Elena Petena, Tomislav Cvitkovic, Valery Tsimashok (Hannover); Matthias Gorenflo, Sebastian Uhl, Matthias Karck, Tsvetomir Loukanov, Viola Deneke (Heidelberg); Hashim Abdul-Khaliq, Axel Rentzsch, Gloria Färber (Homburg); Thomas Kriebel, Michael Zimmer, Peter Follmann (Kaiserslautern); Anselm Uebing, Gunther Fischer, Jan-Hinnerk Hansen Kolja Becker, Ulrike Hoffmann, Jens Scheewe, Tim Attmann, Jill Jussli-Melchers (Kiel); Ingo Dähnert, Frank-Thomas Riede, Martin Kostelka (Leipzig); Nikolaus A. Haas, André Jakob, Christoph Funk, Felix Sebastian Oberhoffer, Guido Mandilaras, Matthias Hermann, Roxana Engmann Roxana Riley, Simone Dold, Jürgen Hörer (Großhadern, München); Hans-Gerd Kehl, Felix Kleinerüschkamp, Volker Debus, Sven Martens, Sabrina Martens, Erdal Yörük, Fadi Almuhrez, Katarzyna Januszewska, Lofti Ben Mime, Helmut Baumgartner (Münster); Matthias W. Freund, Gerrit Kopiske, Michael Schumacher (Oldenburg); Ulrich Schweigmann, Volker Ocker, Jelena Pabst von Ohain, Ioannis Tzanavaros, Janez Vodiškar (Stuttgart); Johannes Nordmeyer, Jörg Michel, Christan Scheckenbach, Vanya Icheva, Christian Schlensak, Rafal Berger (Tübingen).

Participating Centers in 2021

Universitätsklinikum Aachen; Kinderherzzentrum/Zentrum für angeborene Herzfehler Bad Oeynhausen; Deutsches Herzzentrum der Charité, Berlin; Universitätsklinikum Bonn; Herzzentrum Duisburg; Universitätsklinikum Erlangen; Universitäts-Herzzentrum Freiburg/Bad Krozingen; Universitätsklinikum Gießen; Universitätsklinikum Göttingen; Universitätsklinikum Hamburg-Eppendorf; Medizinische Hochschule Hannover; Universitätsklinikum Heidelberg; Universitätsklinikum des Saarlandes, Homburg; Westpfalz-Klinikum Kaiserslautern; Universitätsklinikum Schleswig-Holstein, Kiel; Herzzentrum Leipzig; Klinikum der LMU Campus Großhadern, München; Universitätsklinikum Münster; Klinikum Oldenburg; Klinikum Stuttgart; Universitätsklinikum Tübingen.

Abbreviations

AE Adverse events
 ASD Atrial septal defect
 AVSD Atrioventricular septal defect
 CHD Congenital heart disease
 ECC Extracorporeal circulation
 GA General anaesthesia

ICU Intensive care unit
 PDA Patent ductus arteriosus
 COA Native coarctation
 ReCOA Re-Coarctation
 PVR Pulmonary valve replacement
 PPVI Percutaneous pulmonary valve replacement
 TCPC Total cavopulmonary connection
 TGA Transposition of the great arteries with intact ventricular septum
 TOF Tetralogy of Fallot
 VSD Ventricular septal defect

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Conflict of interest

None declared.

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