

Reason for readmission following acute coronary syndrome episode code N[N]

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Reason for readmission following acute coronary syndrome episode code N[N]

Identifying and definitional attributes

Metadata item type:	Value Domain
METEOR identifier:	359408
Registration status:	Health , Standard 01/10/2008
Definition:	A code set representing the main reason for the admission following a previous discharge from an acute coronary syndrome episode.

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	ST-segment-elevation myocardial infarction
	2	non-ST-segment-elevation ACS with high-risk features
	3	non-ST-segment-elevation ACS with intermediate-risk features
	4	non-ST-segment-elevation ACS with low-risk features
	5	Percutaneous coronary intervention (PCI)
	6	Coronary artery bypass graft (CABG)
	7	Heart Failure (without MI)
	8	Arrhythmia (without MI)
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:	<p>CODE 1 ST-segment-elevation myocardial infarction</p> <p>This code is used when the reason for admission is persistent ST elevation of ≥ 1mm in two contiguous limb leads, or ST elevation of ≥ 2mm in two contiguous chest leads, or with new left bundle-branch block (BBB) pattern on the ECG.</p> <p>CODE 2 Non-ST-segment-elevation ACS with high-risk features</p> <p>This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:</p> <ul style="list-style-type: none">• repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;• elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);• persistent or dynamic ECG changes of ST segment depression ≥ 0.5mm or new T wave ≥ 2mm;• transient ST-segment elevation (≥ 0.5 mm) in more than 2 contiguous leads;• haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;• sustained ventricular tachycardia;
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- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS); or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction \geq 0.40, or known coronary lesion more than >50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: of known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

CODE 5 Percutaneous coronary intervention (PCI)

This code is used when the reason for admission is for a PCI, where the PCI is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1-4 should be coded.

CODE 6 Coronary artery bypass graft (CABG)

This code is used when the reason for admission is for a CABG, where the CABG is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1-4 should be coded.

CODE 7 Heart failure (without MI)

This code is used when the reason for admission is for the treatment of heart failure, where heart failure is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

CODE 8 Arrhythmia (without MI)

This code is used when the reason for admission is for the treatment of an arrhythmia, where the arrhythmia is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

Relational attributes

Related metadata references:

Supersedes [Reason for readmission following acute coronary syndrome episode code N\[N\]](#)
[Health](#), Superseded 01/10/2008

**Data elements
implementing this value
domain:**

[Person—reason for readmission following acute coronary syndrome episode, code
N\[N\]](#)
[Health](#), Standard 01/10/2008