Acute coronary syndrome clinical event type code N[N]

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# Acute coronary syndrome clinical event type code N[N]

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| Identifying and definitional attributes |
| Metadata item type: | Value Domain |
| METEOR identifier: | 338254 |
| Registration status: | [Health](https://meteor.aihw.gov.au/RegistrationAuthority/12), Standard 01/10/2008 |
| Definition: | A code set representing a significant clinical event/s that may affect health outcomes if experienced by those with acute coronary syndrome.  |

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| Representational attributes |
| Representation class: | Code |
| Data type: | Number |
| Format: | N[N] |
| Maximum character length: | 2 |
|   | **Value** | **Meaning** |
| Permissible values: | 1 | Cardiogenic shock |
|   | 2 | Cardiac rupture |
|   | 3 | Cardiac arrest |
|   | 4 | New or recurrent myocardial infarction |
|   | 5 | Stroke |
|   | 6 | Acute pulmonary oedema |
|   | 7 | Recurrent rest angina with electrocardiogram changes |
|   | 8 | Recurrent rest angina without electrocardiogram changes |
|   | 9 | New onset arrhythmia: atrial |
|   | 10 | New onset arrhythmia: ventricular |
|   | 11 | New onset arrhythmia: heart block (1,2,3) |
|   | 12 | Unplanned revascularisation |
|   | 13 | Acute renal failure |
|   | 14 | Thrombocytopaenia |
| Supplementary values: | 99  | Not stated/inadequately described  |

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| Collection and usage attributes |
| Guide for use: | CODE 1     Cardiogenic shockUse this code when the person has experienced cardiogenic shock, including if the person was in shock at the time of presentation to the hospital.Cardiogenic shock is defined as:- hypotension (systolic BP <90mmHg for at least 30 minutes or the need for supportive measures to maintain blood pressure of greater than or equal to 90mmHg)- end-organ hypoperfusion (cool extremities or a urine output of <30ml/hour, and a heart rate >60 beats/minute)- a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.CODE 2     Cardiac ruptureUse this code when the person has a rupture of the ventricular myocardium, the ventricular septum, or a frank papillary muscle rupture. This includes if the person experienced the rupture before presentation to the hospital.CODE 3     Cardiac arrestUse this code when the person has experienced cardiac arrest (i.e. the lack of effective cardiac output), including if the person was under arrest at the time of presentation to the hospital. CODE 4     New or recurrent myocardial infarctionUse this code when the person experiences a myocardial infarction during hospitalisation distinct from the index event at the time of presentation.Recurrent myocardial infarction is defined by clinical events and cardiac marker elevations after the first 24 hours following presentation to the hospital.For people presenting without initial evidence of myonecrosis, recurrent MI is defined by:- A rise in troponin T or I to greater than the diagnostic threshold level (with precision of 10% coefficient of variation) as defined by the local laboratory; OR- A CK-MB elevation of greater than twice the upper limit of normal for the laboratory (if CK-MB is not available, CK may be used).For people presenting with evidence of myonecrosis:- A further rise in troponin of greater than 25% or a re-elevation in CK-MB of greater than 50% (if no CK-MB is drawn, CK may be used) will define recurrent MI- If the event occurs within 24 hours of PCI, then a level of greater than 3 times the upper limit of normal for CK-MB will be used. If the event occurs within 24 hours of CABG, then a level of greater than 5 times the upper limit of normal for CK-MB will be used.CODE 5     StrokeUse this code if the person experiences a loss of neurological function with residual symptoms remaining for at least 24 hours after onset and which occurred before presentation to the hospital. The occurrence of stroke should be evidenced by a record of cerebral imaging (CT or MRI).CODE 6     Acute pulmonary oedema/congestive heart failureUse this code when the person has experienced acute pulmonary oedema or congestive heart failure with evidence of supportive clinical signs of ventricular dysfunction. These include:- Third heart sound (S3)- Cardiomegaly- Elevated jugular venous pressure (JVP)- Chest X-ray evidence of pulmonary congestion- Requirement for ventilatory assistance (CPAP or intubation).This includes if acute pulmonary oedema or congestive heart failure was present at the time of presentation to the hospital.CODE 7     Recurrent rest angina with electrocardiogram (ECG) changesUse this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin with associated ECG changes.CODE 8     Recurrent rest angina without electrocardiogram (ECG) changesUse this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin without associated ECG changes.CODE 9     New onset arrhythmia: atrialUse this code when the person has experienced an atrial arrhythmia, that was not present before this acute coronary syndrome event, documented by one of the following:- Atrial fibrillation/flutter- Supraventricular tachycardia requiring treatment (i.e. requiring cardioversion, drug therapy, or is sustained for greater than one minute).  CODE 10     New onset arrhythmia: ventricularUse this code when the person has experienced ventricular tachycardia or ventricular fibrillation requiring cardioversion and/or intravenous antiarrhythmics, that was not present before this acute coronary syndrome event.  CODE 11     New onset arrhythmia: heart block (1,2,3)Use this code when the person has experienced first, second or third degree atrioventricular block with bradycardia with or without the requirement for pacing.CODE 12     Unplanned revascularisationUse this code when the person has undergone revascularisation precipitated by 20 minutes or more of recurrent chest pain with/or without objective evidence of ischaemia on the ECG.  Code 13     Acute renal failure Use this code when the person has acute renal failure as determined by a rise in serum creatinine of x 1.5 or a decrease in GFR by 25% or urine output <0.5mL/kg/h for 6 hours.Code 14     ThrombocytopeniaUse this code when the person has thrombocytopenia as determined by the platelet count: platelet count dropped to less than 100 x 109/L.   |

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| Relational attributes  |
| Data elements implementing this value domain: | [Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]](https://meteor.aihw.gov.au/content/338314)       [Health](https://meteor.aihw.gov.au/RegistrationAuthority/12), Standard 01/10/2008 |