Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]

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Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Acute coronary syndrome related clinical event type
METEOR identifier:	338314
Registration status:	Health, Standard 01/10/2008
Definition:	The type of acute coronary syndrome related clinical event, as represented by a code.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event
METEOR identifier:	338252
Registration status:	Health, Standard 01/10/2008
Definition:	The type of clinical event which can affect the health outcomes of a person with acute coronary syndrome.
Object class:	Person with acute coronary syndrome
Property:	Type of acute coronary syndrome related clinical event

Value domain attributes

Identifying and definitional attributes

Value domain:	Acute coronary syndrome clinical event type code N[N]
METEOR identifier:	338254
Registration status:	Health, 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.

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

Collection and usage attributes

Guide for use:

CODE 1 Cardiogenic shock

Use 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 rupture

Use 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 arrest

Use 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 infarction

Use 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 Stroke

Use 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 failure

Use 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) changes

Use 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) changes

Use 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: atrial

Use 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: ventricular

Use 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 revascularisation

Use 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 Thrombocytopenia

Use this code when the person has thrombocytopenia as determined by the platelet count: platelet count dropped to less than 100 x 10^9/L.

Data element attributes

Collection and usage attributes

Guide for use:

Record all clinical events that the person experiences from the time of presentation to hospital until discharge from hospital.

More than one event may be recorded.

The time and date must be recorded for each clinical event that occurs.

Comments:

An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Source and reference attributes

Reference documents:

Chew DPB et al. National data elements for the clinical management of acute coronary syndromes. Medical Journal of Australia. Volume 182 Number 9. 2 May 2005.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome clinical event cluster
Health, Standard 01/10/2008
Conditional obligation: If a clinical event has occurred, record the clinical event type.
DSS specific information: Codes are to be provided for each clinical event prescribed during this hospital presentation.