

# 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

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

## Representational attributes

<b>Representation class:</b>	Code
<b>Data type:</b>	Number
<b>Format:</b>	N[N]
<b>Maximum character length:</b>	2

	<b>Value</b>	<b>Meaning</b>
<b>Permissible values:</b>	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)
<b>Supplementary values:</b>	99	Not stated/inadequately described

## Collection and usage attributes

**Guide for use:** CODE 1 ST-segment-elevation myocardial infarction

This code is used when the reason for admission is persistent ST elevation of  $\geq 1$ mm in two contiguous limb leads, or ST elevation of  $\geq 2$ mm in two contiguous chest leads, or with new left bundle-branch block (BBB) pattern on the ECG.

CODE 2 Non-ST-segment-elevation ACS with high-risk features

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:

- 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  $\geq 0.5$ mm or new T wave  $\geq 2$ mm;
- transient ST-segment elevation ( $\geq 0.5$  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;

- 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