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]

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| Identifying and definitional attributes | |
| Metadata item type: | Value Domain |
| METEOR identifier: | 359408 |
| Registration status: | [Health!](https://meteor-uat.aihw.gov.au/RegistrationAuthority/14), Standard 01/10/2008 |
| Definition: | A code set representing the main reason for the  [**admission**](https://meteor-uat.aihw.gov.au/content/327206) following a previous discharge from an acute coronary syndrome episode. |

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| Representational attributes | | |
| Representation class: | Code | |
| Data type: | Number | |
| Format: | N[N] | |
| Maximum character length: | 2 | |
|  | **Value** | **Meaning** |
| Permissible values: | 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 |

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| 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 >=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.  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 >= 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; * 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 >= 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. |

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| Relational attributes | |
| Related metadata references: | Supersedes [Reason for readmission following acute coronary syndrome episode code N[N]](https://meteor-uat.aihw.gov.au/content/285169)  [Health!](https://meteor-uat.aihw.gov.au/RegistrationAuthority/14), Superseded 01/10/2008 |
| Data elements implementing this value domain: | [Person—reason for readmission following acute coronary syndrome episode, code N[N]](https://meteor-uat.aihw.gov.au/content/359404)  [Health!](https://meteor-uat.aihw.gov.au/RegistrationAuthority/14), Standard 01/10/2008 |