ACIP

DATA TAPE CODING MANUAL

SECTION 1

MAY 1996

ACIP
DATA TAPE CODING MANUAL
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DATA TAPE CODING MANUAL

General Introduction

The Asymptomatic Cardiac Ischemia Pilot (ACIP), a multicenter, international clinical trial, was designed to establish whether or not a randomized clinical trial of therapies for asymptomatic ischemia to reduce mortality and the rate of occurrence of myocardial infarction is feasible.

Major objectives of ACIP were to: a) compare the safety and efficacy of three randomly assigned strategies to suppress ischemia; and b) clarify issues affecting feasibility of a large trial, such as patient availability for randomization, compliance with therapies, and estimates of fatal and non-fatal events. The three management strategies were: (1) revascularization of all important stenoses; (2) angina-guided therapy with incremental levels of anti-ischemic medication to relieve angina; and (3) angina-guided plus ambulatory ECG (AECG)-guided therapy with incremental levels of anti-ischemic medication to eliminate both angina and ischemia detected by AECG monitoring. In the two medical strategies, treatment for asymptomatic cardiac ischemia was placebo-controlled and administered double-blind. Within each management strategy, patients were assigned randomly to one of two medical regimens (atenolol followed by nifedipine or diltiazem followed by isosorbide dinitrate) unless one of the regimens was specifically indicated or contraindicated.

Men and women who had 1) angiographic evidence of obstructive coronary artery disease amenable to revascularization; 2) evidence of stress-related ischemia during an ACIP protocol treadmill or an alternative stress test if the patient could not exercise; and 3) at least one episode of asymptomatic ischemia (ST segment deviation $\geq$ 1 mm from baseline $\geq$ 1 min and separated from other episodes by at least 5 min) on a 48-hour ambulatory electrocardiogram (AECG) were eligible. The stress test and AECG were performed after all anti-ischemic medication (but sublingual nitroglycerin) had been discontinued for at least 2 to 3 days, except for postinfarction patients who could continue taking atenolol (50 mg once a day) or a slow-release preparation of

diltiazem (60 mg twice daily). If a patient's medication could not be discontinued for these tests, it was continued after entry (referred to as background medication). Patients meeting all eligibility criteria were asked to give informed consent.

A Mortality and Morbidity Classification Committee (MMCC) reviewed all suspect ischemic events and classified each event as either 1) a myocardial infarction (MI), 2) other ischemic event, or 3) no ischemic event. The MMCC adjudicated events rather than clinic reported events are reported in all ACIP manuscripts. MMCC adjudicated events are contained on the Suspect Ischemic Event Classification Form 43, the Hospitalization MMCC Classification Form 44 and the Events File. Clinic reported events are contained on the PTCA procedures Form 6A, Follow-up contact Form 13, Subsequent Hospitalization Form 14, and CABG Surgery Form 25.

The primary end point to assess the three management strategies was elimination of cardiac ischemia on 48-hour AECG performed at the 12-week visit. The presence of ischemia on the AECG at the six month and one-year visit, and the presence of arrhythmia on 48-hour AECGs were also analyzed. Clinical events (death, MI, occurrence of unstable angina, etc.) were ascertained at the time of each follow-up visit.

The tape contains data for 558 of the original 618 patients randomized in ACIP. Data from one clinical center were found to be of unacceptable quality, so all 60 patients enrolled at that center have been excluded (Conti et al., 1995 correction JACC, see references listed on page vii). However, the inclusion or exclusion of these patients did not change the results. Forms for 1820 patients screened for ACIP were received from the Clinical Centers. Patients were enrolled from October 23, 1991 through February 1, 1993. At the close of follow-up, one-year vital status was known for all patients. In addition, 238 patients were contacted at month 18 and 13 patients were contacted at month 24. Data are from analyses files as of January 1995.

Description of Variables on the Data Tape

The analysis file documentation contains the items, variable names and possible codes.

Copies of ACIP forms with annotations denoting the variable names are being submitted in a separate binder with this manual (see Section 2).

Data Tape Specification

The accompanying tape is g-track, unlabeled, with a density of 6250 bpi, Volume M24839. Tape specifications: SAS datasets version 6.07, in transport format. The SAS default file specifications are record length 80, blocksize 8000, fixed block. The code used to copy the files to tape as well as to uncopy from tape to the data base is provided below. A copy of the transport order produced from the SAS transport run is enclosed in the box with the tape.

CODE USED TO CREATE SAS TRANSPORT FILE ON TAPE M24389

```
data _null_;
call system('mt -f /dev/rmt/2hn fsf 0');
run;
libname newlib xport '/dev/rmt/2hn';
libname oldlib '/udd/ragacip/final0596';
proc copy in=oldlib out=newlib memtype=data;
run;
endsas;
```

CODE TO COPY TRANSPORTED DATA BACK OUT FROM TAPE

```
data _null_;
call system ('mt -f /dev/rmt/2h fsf 0');
run;
libname newlib xport '/dev/rmt/2h';
libname oldlib '/udd/ragacip/test';
proc copy in=newlib out=oldlib;
run;
endsas;
```

The tape contains 44 SAS files corresponding to ACIP forms or data files. SAS output documenting each variable with means for continuous variables and frequency distributions for discrete variables is being submitted in a separate binder (see Section 3).

Special Considerations

a) The original identification number containing clinic and patient number has been replaced with a new sequence number, NEWID (l-1820).

b) Time is recorded in military time.

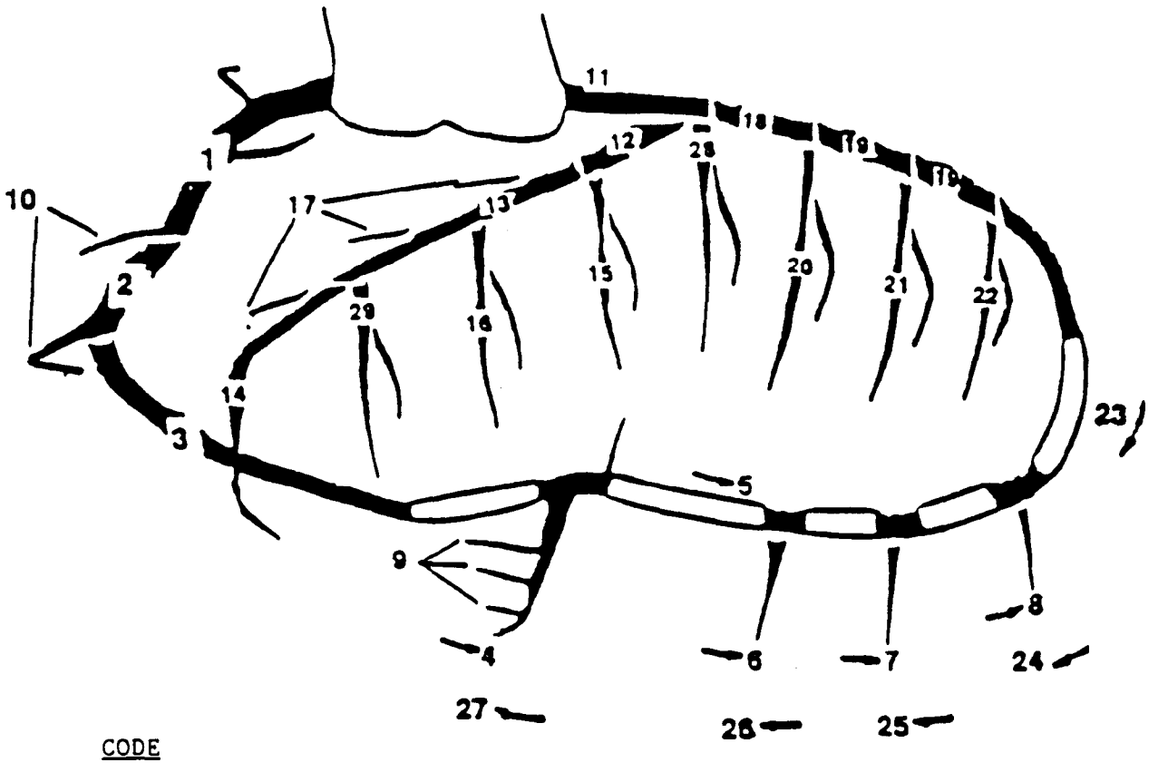
c) Days to event, procedure or visit are calculated with reference to study enrollment date. For screened patients not randomized to treatment, study enrollment date is defined as screening date. Time to an event, procedure or visit occurring on the same date as study enrollment is defined as zero days. Time of qualifying procedures occurring prior to study enrollment are reported as negative numbers.

d) Visit type is coded as follows:

QVOO = Qualifying Visit
QV01 = Repeat qualifying AECG
IT01 = Initial Treatment (Protocol procedure PTCA or CABG)
RV01 = Randomization Visit
WK04 = Week 04 Visit
WK08 = Week 08 Visit
WK12 = Week 12 Visit
MN06 = Month 06 Visit
MN09 = Month 09 Visit
MN12 = Month 12 Visit
MN18 = Month 18 Visit
MN24 = Month 24 Visit

e) Coronary artery site codes are defined on the Coronary Artery diagram contained on the next page.

ACIP Coronary Artery Diagram



CODE

01 Proximal right coronary artery (Prox RCA)
02 Mid-right coronary artery.(Mid RCA)
03 Distal right coronary artery (Dist RCA)
04 Right posterior descending artery (RDPA)
OS Right posterior atriovencricular (RPLS)
06 First right posterolateral (1st RPL)
07 Second right posterolateral (2nd RPL)
08 Third right posterolateral (3rd RPL)
09 Posterior descending septal perforators (Inf septal)
LO Acute marginal (Ac marg)
11 Left main coronary artery (LMCA)
12 Proximal TAD artery (Prox LAD)
13 Hid LAD artery (Mid LAD)
14 Distal LAD artery (Dist LAD)
15 First diagonal branch (1st Diag)
16 Second diagonal branch (2nd Diag)
17 First septal perforator (1st Septal)
18 Proximal circumflex artery (Prox CX)
19 Hid circumflex artery (Mid, dist CX)
20 First obtuse marginal branch (1st Ob marg)
21 Second obtuse marginal branch (2nd Ob marg)
22 Third obtuse marginal branch (3rd Ob marg)
23 Circumflex artery AV groove continuation (LAV)
24 First Left posterolateral branch (1st LPL)
25 Second left posterolateral branch (2nd LPL)
26 Third Left posterolateral branch (3rd LPL)
27 Left posterior descending artery (LPDA)
28 Ramus intermedius (Ramus)
29 Third diagonal branch (3rd Diag)

Glossary of Abbreviations

ACE	Angiotensin converting enzyme
AECG	Ambulatory electrocardiogram
A/N	Atenolol/Nifedipine regimen
BB	Beta-blocker
BP	Blood pressure
bpm	beats per minute
CABG	Coronary artery bypass graft
CAD	coronary artery disease
CHF	congestive heart failure
cx	circumflex
D/I	Diltiazem/Isosorbide Dinitrate regimen
ETT	Exercise Treadmill Test, Exercise Tolerance Test
HH:MM:ss	time format hours:minutes:seconds
HR	Heart rate
IMA	Internal mammary artery
IV	Intravenous
IVCD	Idioventricular conduction defect
LAD	Left anterior descending
LAO	Left anterior oblique
METS	Metabolic equivalents (measure of workload on ETT)
MI	Myocardial infarction
MMCC	Mortality and Morbidity Classification Committee
PTCA	percutaneous transluminal coronary angioplasty
RAO	right anterior oblique
RBBB	right bundle branch block
RCA	right coronary artery
RPE	Rating of perceived exertion
SVG	saphenous vein graft
SVT	supra ventricular tachycardia
VPB	ventricular premature beat

Further Information on ACIP

For further information on the ACIP study, the user is directed to the following publications.

1. The ACIP Investigators. Asymptomatic Cardiac Ischemia Pilot study (ACIP). Am J Cardiol 1992;70:744-747.

2. McMahon RP, Proschan M, Geller NL, Stone PH, Sopko G, for the ACIP Investigators. Sample size calculation for clinical trials in which entry criteria and outcomes are counts of events. Statistics in Medicine 1994;13:859-870.

3. Pepine CJ, Geller NL, Knatterud GL, Bourassa MG, Chaitman BR, Davies RF, Day P, Deanfield JE, Goldberg AD, McMahon RP, Mueller H, Ouyang P, Pratt C, Proschan M, Rogers WJ, Selwyn AP, Sharaf B, Sopko G, Stone PH, Conti CR for the ACIP Investigators. The Asymptomatic Cardiac Ischemia Pilot (ACIP) study: Design of a randomized clinical trial, baseline data and implications for a long-term outcome trial. J Amer Coll Cardiol 1994;24:1-10.

4. Knatterud GL,Bourassa MG, Pepine CJ, Geller NL, Sopko G, Chaitman BR, Pratt C, Stone PH, Davies RF, Rogers WJ, Deanfie-ld JE, Goldberg AD, Ouyang P, Mueller H, Sharaf B, Day P, Selwyn AP, Conti CR for the ACIP Investigators. Effects of treatment strategies to suppress ischemia in patients with coronary artery disease: 12-week results of the Asymptomatic Cardiac Ischemia Pilot (ACIP) Study. J Amer Coll Cardiol 1994;24:11-20.

5. Rogers WJ, Bourassa MG, Andrews TC, Bertolet BD, Blumenthal RS, Chaitman B, For-man S, Geller NL, Goldberg AD, Habib GB, Masters RG, Moisa RB, Mueller H, Pearce DJ, Pepine C, Sopko G, Steingart RM, Stone PH, Knatterud GL, Conti CR for the ACIP Investigators. The Asymptomatic Cardiac Ischemia Pilot (ACIP) Study: Outcome at One Year for Patients with Asymptomatic Cardiac Ischemia Randomized to Medical Therapy or Revasculari-zation. J Amer Coll Cardiol 1995;26:594-605.

6. Chaitman BR, Stone PH, Knatterud GL, Forman SA, Sopko G, Bourassa MG,Pratt C, Rogers WJ, Pepine CJ, Conti CR for the ACIP Investigators. Asymptomatic Cardiac Ischemia Pilot (ACIP) Study: Impact of Anti-Ischemia Therapy on 12-Week Rest ECG and Exercise Test Outcomes. J Amer Coll Cardiol 1995;26:-585-93.

7. Bourassa MG, Pepine CJ, Forman SA, Rogers WJ, Dyrda I, Stone PH, Chaitman BR, Sharaf B, Mahmarian J, Davies RF, Knatterud GL, Terrin M, Sopko G, Conti CR for the ACIP Investigators. Asymptomatic Cardiac Ischemia Pilot (ACIP) Study: Effects of Coronary Angioplasty and Coronary Artery Bypass Graft Surgery on Recurrent Angina and Ischemia. J Amer Coll Cardiol 1995;26:606-14.

8. Conti CR, Knatterud GL, Sopko G: Correction. J Amer Coll Cardiol 1995;26:842.

9. Bourassa MG, Knatterud GL, Pepine CJ, Sopko G, Rogers WJ. Geller NL, Dyrda I, Forman SA, Chaitman BR, Sharaf B, Davies RF, Conti CR for the ACIP Investigators. Asymptomatic Cardiac Ischemia Pilot (ACIP): Improvement of Cardiac Ischemia at 1 Year Following PTCA and CABG. Circulation 1995;92 (suppl II): 11-l-11-7.

ACIP ANALYSIS FILES

ARRANGEMENT OF FILES BY SOURCE

SOURCE	SAS FILE NAME	NUMBER OF RECORDS	NUMBER OF VARIABLES
Form 3D, 3E	FM3D3E.SSD01	1820	11
Form 04	FM04.SSD01	558	46
Form 6A	FM6A.SSD01	141	51
Form 6B	FM6B.SSD01	26	10
Form 7A	FM7A.SSD01	573	37
Form 8C	FM8C.SSD01	4312	5
Form 8C (reason not done)	FM8CND.SSD01	91	10
Form 8E	FM8E.SSD01	2413	90
Form 8E (reason not done)	FM8END.SSD01	127	10
Form 10	FM10.SSD01	4048	12
Form 11	FM11.SSD01	2693	41
Form 13	FM13.SSD01	3498	68
Form 13 (Calculated)	FORM13.SSD01	3498	10
Form 13 mg/day dose	MGDOSE.SSDOl	3498	18
Form 14	FM14.SSD01	201	17
Form 25	FM25.SSD01	155	70
Form 43	FM43.SSD01	122	3
Form 44	FM44.SSD01	201	3
Form 66	FM66.SSD01	113	22
Form 6A,14,15,23,25, 43,44	EVENT.SSD01	558	21
Angina symptoms (Calculated)	QVSYMP.SSDOl	558	5
Protocol procedures (Calculated)	PTCACABG.SSD01	192	6
Primary end point (Calculated)	IMPUTE.SSD01	558	7
<u>Inventory</u>			
Eligibility Record	ELIGALL.SSD01	1820	4
Follow-up Status	FVINVNEW.SSD01	558	9

ACIP ANALYSIS FILES (Continued)

ARRANGEMENT OF FILES BY SOURCE

SOURCE	SAS FILE NAME	NUMBER OF RECORDS	NUMBER OF VARIABLES
AECG Core Lab Data			
Summary Data (all visits)	FINLST.SSD01	4069	20
Calculated Summary Data (all visits)	FINLAECG.SSD01	558	89
Episode Data (QV only)	STEPISOD.SSD01	6492	16
Arrthymia Data (all visits)	ARRHY. SSD01	6374	36
Rest and Exercise ECG Core Lab Data			
Rest Data (all visits)	ECGREST.SSD01	2125	33
Exercise Data (all visits)	ETTECGX.SSD01	2438	33
QV Calculated ETT Data	ETTQV.SSD01	558	32
WK12 Calculated ETT Data	ETTWK12.SSD01	512	31
MN06 Calculated ETT Data	ETTMN06.SSD01	494	31
MN12 Calculated ETT Data	ETTMN12.SSD01	491	31
Angiography Core Lab Data			
Form 7F - Qualifying	FM7FANG.SSD01	658	178
Calculated QV	QV7FNEW.SSD01	558	110
Form 7F - Protocol PTCA	FM7FPTCA.SSD01	94	130
Calculated Protocol PTCA	PTCA7F.SSD01	92	64
Form 7F - Normal Coronary Substudy Patients	FM7FNCAD.SSD01	84	178
Calculated	NCAD7F.SSD01	84	95
Form 7F - AECG Ineligible Substudy Patients			
Calculated	INEL7F.SSD01	43	95
Form 7F - Thallium Substudy Patients	FM7FTHAL.SSD01	53	178
Calculated	THAL7F.SSD01	53	95

ACIP
FORM 3D/3E
CONFIRMATION OF ELIGIBILITY
& CHANGE OF STATUS FORM
FM3D3E.SSD01

FORM/ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
3D/4	SEX	Sex 1= Male, 2= Female
3D/5	WHITE	Race 0= Other 1= White
3D/6A	AGE	Age
3D/7	ABSCETT	Abnormal Screening ETT 1= Yes, 2= no
3D/8	OBCAD	Angiographic evidence of obstructive CAD 1= Yes, 2= No, 3= NA
3D/8B	GT1CAN50	At least one coronary artery narrowing >= 50% disease 1= Yes, 2= No, 3= NA
3D/11	TRT_ASMT	Medication regimens to which patient may be assigned 1= Random assignment with no restrictions 2= Atenolol/Nifedipine without background therapy 3= Atenolol/Nifedipine with background therapy 4= Dilitiazem /Isosorbide Dinitrate without background therapy 5= Dilitiazem /Isosorbide Dinitrate with background therapy
3D/12	STRAT03	Angina1 status during the 6 weeks prior to qualifying AECG 1= Symptomatic 2= Asymptomatic
3D/13	PREVCABG	Previous CABG > 3 months prior to qualifying AECG 1= Yes, 2= No

3E/3	INELREA	Primary reason for ineligibility 01= Qualifying angiogram shows that the patient does not have CAD which meets study eligibility 02= Qualifying angiogram shows that patient is not suitable for revascularization 03= Qualifying exercise test shows that patient does not meet study eligibility 04= Qualifying AECG shows that patient does not meet study eligibility 05= Exclusion criteria 06= Death 07= MI 08= PTCA 09= Patient not willing to participate 10= Patient missed Qualifying Visit 11= Personal physician not willing for patient to participate 12= Other

ACIP
FORM 04
BASELINE FORM
FM04.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
3	EDUC	Education 1= Grade 11 or less 2= HS graduate 3= HS graduate + additional training 4= college graduate 5= college graduate + additional training 6= Unknown
5	MARITAL	Current marital status 1= Married 2= Separated or divorced 3= Widowed 4= Not married, spouse-like relationship 5= Single
8	EMPL	Employment at time of screening 1= Full time, 2= Part-time, 3= Retired, 4= Disabled, 5= Unemployed
9	MIHIST	History of MI 1= Yes, 2= No, 3= Unknown
10	CHF	History of CHF requiring treatment 1= Yes, 2= No, 3= Unknown
10A	CHFCLASS	Current Functional Classification 1= One, 2= Two, 3= Three, 4= Four
11	SMOKER	History of cigarette smoking 1= Yes, 2= No
11A	CURSMOKE	Current smoker(within 4 weeks) 1= Yes, 2= No
12	CADB55	Family history of CAD 1= Yes, 2= No, 3= Unknown
13	HPT	History of hypertension requiring treatment 1= Yes, 2= No, 3= Unknown
14	DIABETES	History of diabetes 1= Yes, 2= No, 3= Unknown
14A	DIABRX	Current therapy for diabetes 1= Oral medical, 2= Insulin, 3= Neither, 4= Both
15	HICHOL	History of hypercholesterolemia 1= Yes, 2= No, 3= Unknown
16A	STROKE	Cerebrovascular accident, transient ischemic attack or carotid surgery 1= Yes, 2= No, 3= Unknown
16B	PVD	Peripheral vascular disease 1= Yes, 2= No, 3= Unknown
16C	ASTHMA	Asthma 1= Yes, 2= No, 3= Unknown
16D	BRONCH	Bronchitis 1= Yes, 2= No, 3= Unknown
		Any prior cardiovascular procedures Codes for 17A - 17C 1= Yes, 2= No, 3= Unknown

17A	PTCA	PTCA
17B	OTHRTECH	Other cardiac revascularization interventional technique
17C	HTSURG	Heart surgery other than CABG
		Codes for 18A - 180 1= Yes, 2= No, 3= Unknown
18A	LAN	Long acting nitrates
18B	SAN	Short acting nitrates
18C	BB	Beta blocker therapy
18D	CCB	Calcium channel blockers
18E	ASA	Aspirin
18F	DIPSULF	Dipyridamole/Sulfinpyrazone
18G	ANTIPLAT	Antiplatelet agents
18H	ANTICOAG	Anticoagulant
181	LIPID	Lipid lowering agent
18J	DIUR	Diuretics
18K	ACE	ACE inhibitor
18L	OTHRVAS	Other vasodilators or antihypertensives
18M	ANTIARR	Antiarrhythmic agent
18N	DIGITAL	Digitalis
18O	IN-VITRO	IV nitroglycerin
19,20	BMI	Body mass index calculated
21A	SBP	Systolic BP (mm Hg) 998= missing
21B	DBP	Diastolic BP (mm Hg) 998= missing
22	HTRATE	Heart rate (bpm) 998= missing
23A	s3	S3 1= Yes, 2= No
23B	RALES	Rales that do not clear with cough 1= Yes, 2= No
23C	JVP	Jugular venous pressure > 8 cm of water 1= Yes, 2= No
23D	BRUIT	Carotid bruit 1= Yes, 2= No
23E	PEREDEMA	Peripheral edema 1= Yes, 2= No
23F	HEPATOME	Hepatomegaly 1= Yes, 2= No

ACIP
FORM 6A
PTCA PROCEDURES
FM6A.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to date of PTCA procedures
4		Check all reasons for revascularization
		Possible answers for Items 4A - 4H 1= Yes
4A	MIPROC	MI
4B	ANGPROC	Unstable Angina
4c	CCSCPROC	Canadian Cardiovascular Society Classification of Angina Class III or IV
4D	ECGPROC	Severe ischemic response on exercise ECG
4E	ANATPROC	Coronary Anatomy
4F	PHYSPROC	Decision of personal physician
4G	CLINPROC	Clinical decision not specified by protocol
4H	OTHPROC	Other
5	PRIORITY	Priority of procedure 1= Urgent, 2= Elective
6	ANGSTAT	Angina1 status at time of procedure 1= None, 2= Stable, 3= Unstable, 4= Acute MI
11	PTCOND	Condition of patient upon leaving Cath Lab 1= Stable, 2= Unstable, 3= Deceased
12	OUTCOME	Was intervention outcome successful? 1= Yes, 2= No
13	CASCODE1	Coronary artery segment code Codes 01-29 (See ACIP Coronary Artery Diagram)
13A	NCA1	Native coronary artery or bypass graft 1= Native, 2= Graft
13B	STENPRE1	Stenosis pre-intervention
13D	STENPST1	Stenosis post-intervention 998= Not available
14	CASCODE2	Coronary artery segment code Codes 01-29 (See ACIP Coronary Artery Diagram)
14A	NCA2	Native coronary artery of bypass graft 1= Native, 2= Graft
14B	STENPRE2	Stenosis pre-intervention
14D	STENPST2	Stenosis post-intervention
15	CASCODE3	Coronary artery segment code Codes 01-29 (See ACIP Coronary Artery Diagram)

FORM 6A **(Continued)**

15A	NCA3	Native coronary artery of bypass graft 1= Native, 2= Graft
15B	STENPRE3	Stenosis pre-intervention
15D	STENPST3	Stenosis post-intervention
16	CASCODE4	Coronary artery segment code Codes 01-29 (See ACIP Coronary Artery Diagram)
16A	NCA4	Native coronary artery of bypass graft 1= Native, 2= Graft
16B	STENPRE4	Stenosis pre-intervention
16D	STENPST4	Stenosis post-intervention
17	MAJOREVT	Did patient experience any major events during or within 24 hours after PTCA? 1= Yes, 2= No, 3= Unknown
		Major Events Codes for Items 17A - 17S 1= Did not occur 2= Occurred in lab 3= occurred within 24 hours
17A	DTHPTCA	Death
17B	CAPTCA	Non-fatal cardiac arrest
17c	MIPTCA	Suspected non-fatal MI
17D	RECLPTCA	Abrupt reclosure
17E	CHFPTCA	CHF isolated or pulmonary edema
17F	SHKPTCA	Cardiogenic shock
17G	TAMPPTCA	Cardiac tamponade
17H	HMRRPTCA	Hemorrhage requiring transfusion
171	EMBPTCA	Arterial embolus of extremity or loss of pulse requiring treatment
17J	HYPOPTCA	Hypotension requiring treatment
17K	TIAPTCA	Transient ischemia attack
17L	STRKPTCA	Stroke
17M	COMAPTCA	Coma
17N	ALLGPTCA	Hypersensitivity reaction
170	ARDSPTCA	Respiratory failure
17P	PEPTCA	Pulmonary etnbolus
17Q	RENLPTCA	Renal failure requiring dialysis
17R	CABGPTCA	Emergency CABG
17S	OTHPTCA	Other events

ACIP
FORM 6B
REVASCULARIZATION NON-PERFORMANCE FORM
FM6B.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
3A	PHYREF	Physician refused 1= Yes, 2= No
3B	PTREF	Patient refused 1= Yes, 2= No
3c	PTDEAD	Patient deceased 1= Yes, 2= No
3D	CATHNA	Complications of catheterization 1= Yes, 2= No
3E	ANATOMY	Unsuitable anatomy 1= Yes, 2= No
3F	NOLESION	Inability to cross the lesion 1= Yes, 2= No
3G	NODILATE	Inability to dilate the lesion 1= Yes, 2= No
3H	INTEREVT	Intercurrent event 1= Yes, 2= No
31	NOVASOTH	Other reason revascularization was not performed 1= Yes, 2= No

ACIP
FORM 7A
QUALIFYING CARDIAC CATHETERIZATION
AND ANGIOGRAPHY FORM
FM7A.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
3A	RCA	Vessel or major branch diseased RCA 1= Yes, 2= No
3B	LAD	LAD 1= Yes, 2= No
3c	LCX	LCX 1= Yes, 2= No
3D	BYPASS	Bypass graft 1= Yes, 2= No On revision 3 only, missing on other revisions
		For each lesion >=50% diameter stenosis for Items 4A - 4J
4A1-4J1	ACA - ACJ	Artery codes 01-29 (See ACIP Coronary Artery Diagram)
4A2-4J2	VGRAFTA- VGRAFTJ	Vein graft 1= Yes, 2= No Only on revision 3, missing on other revisions
4A3-4J3	STENA- STENJ	Percent stenosis
6D	EF	Global ejection fraction
7	REVPERF	Procedure to be performed if this patient is assigned to revascularization 1= PTCA, 2= Staged PTCA, 3= CABG Not on revision 1

Doc. form7a.wp

ACIP
FORM 8C
AECG RECORD SHIPPING
FM8C.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to date of study
10	ISCHREC	Did patient have episode of ischemic chest pain during the recording? 1= Yes, 2= No, 8= Not available
10A	EVTMARK	Was patient compliant in using marker? 1= Yes, 2= No, 8= Not available

ACIP
FORM 8C
AECG RECORD SHIPPING FORM
REASON NOT DONE VARIABLES
FM8CND.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
	ND	AECG not performed Should always be 1
4		Reason procedure was not performed: Code Items 4A - 4G 1= Yes
4A	PHYREF	Physician refused
4B	PTREF	Patient refused
4c	CONTCARD	Procedure contraindicated (cardiac reason)
4D	CONTPHYS	Procedure containdicated (physical disability or other reason)
4E	NOEQUIP	Equipment unavailable
4F	BADEQUIP	Equipment malfunctioned
4G	NOPEROTH	Other reason

ACIP
FORM 8E
ACIP EXERCISE TOLERANCE TEST FORM
FM8E.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to date of study
		Medication prior to ETT Codes for Items 6A - 6D 1= Yes, 2= No, 3= Unknown
6A	NIT2HR	Nitrates
6B	BB48	Beta-blockers
6C	CCB24	Calcium channel blockers
6D	DIGIT2WK	Digitalis
7A	ETTPROT	Protocol description 1= Standard ACIP, 2= Modified ACIP
7B	ETTSCND	Total exercise time in seconds
7c	FINSTGE	Final stage of exercise entered (01 to 13)
8A	ETTPRIM	Primary Reason for stopping:(01-17) 01= Angina 02= ST-segment depression >= 3.0 mm 03= ST-segment elevation >= 1.0 mm 04= Ectopic supraventricular tachycardia 05= Ventricular tachycardia 06= Hypertension 07= hypotension 08= fatigue/exhaustion 09= Dyspnea 10= Ataxia 11= Bradycardia 12= Poor motivation 13= Physician's request 14= Technical problems 15= Adequate heart rate achieved 16= Claudication 17= Other
8B	ETT2ND	Secondary reasons for stopping:(01-17) See Item 8A above for description of codes
10A2	HRA	Heart rate standing at rest
10A3	SBPA	Systolic Blood Pressure standing at rest
10A4	DBPA	Diastolic Blood Pressure standing at rest

FORM 8E (Continued)

10B2- 10K2	HRB- HRK	Heart rate at stage 01-10
10B3- 10K3	SBPB- SBPK	Systolic BP at stage 01-10
10B4- 10K4	DBPB- DBPK	Diastolic BP at stage 01-10
10B5- 10K5	BORGB- BORGK	RPE Scale at stage 01-10
		Recovery (A), each minute for 5 minutes (B-F) prolonged recovery (G)
11A2- llG2	RHRA- RHRG	Heart Rate
11A3- llG3	RSBPA- RSBPG	Systolic Blood Pressure
llA4 llG4	RDBPA- RDBPG	Diastolic Blood Pressure
11G1MN	RPROMIN	Minutes of prolonged recovery time
11G1SEC	RPROSEC	Seconds of prolonged recovery time
12	ETTANG	Angina occurred during study 1= Yes, 2= No, 3= Uncertain
12A	ONSTGE	Onset stage 01 - 11= During exercise 98= Not available RO - R5= During recovery R+= Prolonged recovery
12BMIN	ONMIN	Onset time minutes
12BSEC	ONSEC	Onset time seconds
12c	ANGWORSE	Did angina worsen? 1= Yes, 2= No, 8= Not available
12F	OFFSTGE	Offset stage (Same as Onset Stage)
12GMIN	OFFMIN	Offset time minutes
12GSEC	OFFSEC	Offset time seconds
CALC	FINHR	Final stage heart rate value from items 10B2 - 10K2
CALC	FINSBP	Final stage systolic BP value from items 10B3 - 10K3
CALC	FINDBP	Final stage diastolic BP value from items 10B4 - 10K4
CALC	FINRPE	Final stage RPE value from items 10B5 - 10K5

ACIP .
FORM 8E
ACIP EXERCISE TOLERANCE TEST FORM
REASON NOT DONE VARIABLES
FM8END.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
	ND	ETT not performed Should always be 1
4		Reason procedure was not performed: Codes for Items 4A - 4G 1= Yes
4A	PHYREF	Physician refused
4B	PTREF	Patient refused
4c	CONTCARD	Procedure contraindicated (cardiac reason)
4D	CONTPHYS	Procedure containdicated (physical disability or other reason)
4E	NOEQUIP	Equipment unavailable
4F	BADEQUIP	Equipment malfunction
4G	NOPEROTH	Other reason

Doc. form8end.wp

ACIP
FORM 10
ANGINA QUESTIONNAIRE
FM10.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
3	ANGDAILY	Angina past 4 weeks 1= Yes, 2= No, 3= Unknown
4	STABLE	Angina interferes with daily activity 1= Yes, 2= No
5	CATANG	Categorize angina 1= Stable, 2= Unstable
5A1	PHYACT	Angina related to physical activity 1= None at all 2= 1 to 3 times a month 3= 1 to 2 times a week 4= Greater than or equal to 3 times a week but < 1 time a day 5= 1 to 3 times a day 6= 4 or more times a day
5A2	NOPHYACT	Angina unrelated to physical activity 1= None at all 2= 1 to 3 times a month 3= 1 to 2 times a week 4= Greater than or equal to 3 times a week but c 1 time a day 5= 1 to 3 times a day 6= 4 or more times a day
5B	ANGCLASS	Canadian Cardiovascular Society Classification 1= I, 2= II, 3= III, 4= IV, 9= NA
5C1	ACCELANG	Accelerating angina 1= Yes, 2= No, 3= Unknown
5C2	ANGGT20	Angina lasting > 20 minutes 1= Yes, 2= No, 3= Unknown
5C3	ANGREST	Angina at rest 1= Yes, 2= No, 3= Unknown
5C4	ANGHOSP	Patient hospitalized for above symptoms 1= Yes, 2= No, 3= Unknown

ACIP
FORM 11
MEDICATION PRESCRIPTION AND ADJUSTMENT FORM
FM11.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to contact date
7		Decrease in ACIP Medication Codes for Items 7A - 7H 1= Yes
7A	DECRATOP	Atenolol open label
7B	DECRNIOP	Nifedipine open label
7c	DECRDIOP	Diltiazem open label
7D	DECRISOP	Isosorbide Dinitrate open label
7E	DECRATBL	Atenolol blinded
7F	DECRNIBL	Nifedipine blinded
7G	DECRDIBL	Diltiazem blinded
7H	DECRISBL	Isosorbide Dinitrate blinded
		Codes for Items 8A - 8S 1= Side effect occurred 2= No side effect
8A	BRADSE	Bradycardia
8B	HYPOSE	Hypotension
8C	PALPSE	Palpitations
8D	WHEEZSE	Wheezing
8E	DYSPNSE	Dyspnea
8F	COUGHSE	Cough
8G	DEPRSE	Depression
8H	DIZZYSE	Dizziness
81	SYNCOSE	Syncope
8J	FATIGSE	Fatigue
8K	TREMSE	Tremor
8L	HEADSE	Headache
8M	DIARRSE	Diarrhea

FORM 11 (Continued)

8N	NAUSSE	Nausea
80	ANORSE	Anorexia
8P	RASHSE	Rash
8Q	FLUSHSE	Flushing
8R	EDEMASE	Edema
8S	SEOTH	Other side effect
9	BACKMED	Background Atenolol or Diltiazem medication 1= None 2= Atenolol 50 mg qd 3= Diltiazem 60mg bid
11A	OPENREG	Open Label 1= Regimen D/I 2= Regimen A/N 3= None
11A1	OPDIDOS	Dilitiazem bid 1= None, 2= 60mg, 3= 90mg, 4= 120mg, 5= 180mg, 6= other
11A2	OPISDOS	Isosorbide Dinitrate bid 1= None, 2= 20mg, 3= 40mg, 4= 60mg, 5= 80mg, 6= other
llA3	OPATDOS	Atenolol qd 1= None, 2= 50mg, 3=100mg, 4=150mg,5= 200mg, 6= other
11A4	OPNIDOS	Nifedipine qd 1= None, 2= 30mg, 3= 60mg, 4= 90mg, 5= 120mg, 6= other
11B	BLNDREG	Blinded Regimen 1= Regimen D/I, 2= Regimen A/N, 3= None
11B1	BLDIDOS	Dilitiazem/placebo bid 1= None, 2= 60mg, 3= 90mg, 4= other
11B2	BLISDOS	Isosorbide Dinitrate/Placebo bid 1= None, 2= 20mg, 3= 40mg, 4= other
11B3	BLATDOS	Atenolol/Placebo qd 1= None, 2= 50mg, 3= 100mg, 4= other
11B4	BLNIDOS	Nifedipine/Placebo qd 1= None, 2= 30mg, 3=60mg,4=other

ACIP
FORM 13
FOLLOW-UP CONTACT FORM
FM13.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to contact date
		Codes for Items 4A - 4F 1= Yes, 2= No
4A	DEATHEP	Death endpoint
4B	MIEP	MI endpoint
4c	ANGEP	Rest Angina
4D	INCMEDEP	Angina requiring increase in medication
4E	CARDEP	Cardiac arrest
4EDT	CARDDAYS	Days from enrollment to date of cardiac arrest
4F	STRKEP	Stroke
4FDT	STRKDAYS	Days from enrollment to date of stroke
5	NEWCHF	Evidence of new or worsening CHF since last follow-up 1= Yes, 2= No, 3= Unknown
5A	CHFCLASS	Current New York Association Functional Classification. 1= One, 2= Two, 3= Three, 4= Four, 9= Not available
6	HOSPCE	Hospitalized since last follow-up 1= Yes, 2= No, 3= Unknown
7	PROCS	Special procedures since last follow-up 1= Yes, 2= No, 3= Unknown
7A	ANGIO	Coronary angiography 1= Yes, 2= No
7B	CABG	CABG procedure 1= Yes, 2= No
7c	PTCA	PTCA procedure 1= Yes, 2= No
7D	INTER	Other cardiac revascularization interventional technique 1= Yes, 2= No
7E	SURG	Heart surgery other than CABG 1= Yes, 2= No
8	NEWSE	New onset of any of these symptoms since last scheduled follow-up 1= Yes, 2= No

FORM 13 (Continued)

Code for Items 8A - 8R
1= Side effect occurred
2= No side effect

8A	BRAD	Bradycardia
8B	HYPO	Hypotension
8C	PALP	Palpitations
8D	WHEEZ	Wheezing
8E	DYSPN	Dyspnea
8F	COUGH	Cough
8G	DEPR	Depression
8H	DIZZY	Dizziness
81	SYNC0	Syncope
8J	FATIG	Fatigue
8K	TREM	Tremor
8L	HEAD	Headache
8M	DIARR	Diarrhea
8N	NAUS	Nausea
80	ANOR	Anorexia
8P	RASH	Rash
8Q	FLUSH	Flushing
8R	EDEMA	Edema
10A	BACKMED	Background Atenolol or Diltiazem medication 1= None, 2= Atenolol 50 mg qd, 3= Diltiazem SR 60 mg bid *For Form 13 revision 1 the last Form 11 relative to the visit has been mapped to the form 13 revision 1 since this information was not collected on revision 1.
11	OPENREG	ACIP Open Label medication prescription at the start of this contact 1= Regimen D/I 2= Regimen A/N 3= None
11A	OPDIDOS	Dilitiazem bid 1= None, 2= 60mg, 3=90mg, 4= 120mg, 5= 180mg, 6= other
11B	OPISDOS	Isosorbide Dinitrate bid 1= None, 2= 20mg, 3=40mg 4= 60mg, 5= 80mg, 6= other
11C	OPATDOS	Atenolol qd 1= None, 2= 50mg, 3=100mg, 4= 150mg, 5= 200mg, 6= other

FORM 13 (Continued)

11D	OPNIDOS	Nifedipine qd 1= None, 2= 30mg, 3= 60mg, 4= 90mg, 5= 120mg, 6= other
12	OPENADH	Best estimate of open label medication ingested since last contact
15	BLNDREG	Blinded Regimen 1= Regimen D/I, 2= Regimen A/N, 3= None
15A	BLDIDOS	Dilitiazem/placebo bid 1= None, 2= 60mg, 3= 90mg, 4= other
15B	BLISDOS	Isosorbide Dinitrate/Placebo bid 1= None, 2= 20mg, 3= 40mg, 4= other
15C	BLATDOS	Atenolol/Placebo qd 1= None, 2= 50mg, 3= 100mg, 4= other
15D	BLNIDOS	Nifedipine/Placebo qd 1= None, 2= 30mg, 3= 60mg, 4= other
16	BLNDADH	Best estimate of blinded medication ingested since last contact
18	DELTAMED	Changes in non ACIP study medications since last follow-up contact 1= Yes, 2= No
		Code for Items 19A - 190 1= Yes, 2= No, 3= Unknown
19A	LAN	Long acting nitrates
19B	SAN	Short acting nitrates
19C	BB	Beta Blocker therapy
19D	CCB	Calcium channel blockers
19E	ASA	Aspirin (ASA)
19F	DIPSULF	Dipyridamole/sulfinpyrazone
19G	ANTIPLAT	Antiplatelet agents other than ASA or dipyridamole or sulfinpyrazone
19H	ANTICOAG	Anticoagulant
191	LIPID	Lipid lowering agent
19J	DIUR	Diuretics
19K	ACE	ACE inhibitors or other hypertensives
19L	OTHRVAS	Other vasodilators or antihypertensives
19M	ANTIARR	Antiarrhythmic agent
19N	DIGITAL	Digitalis
190	IVNITRO	IV Nitroglycerin

CALCULATED FORM 13 VARIABLES
FOLLOW-UP CONTACT FORM
FORM13.SSD01

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
11A/CALC	OPDIDOS	Dilitiazem bid 0 Dose defined* 1= None, 2= 60mg, 3= 90mg, 4=120mg, 5= 180mg, 6= Other
11B/CALC	OPISDOS	Isosorbide Dinitrate bid 0 Dose defined* 1= None, 2= 20mg, 3= 40mg, 4=60mg, 5= 80mg, 6= Other
11C/CALC	OPATDOS	Atenolol qd 0 Dose defined* 1= None, 2= 50mg, 3= 100mg, 4=150mg, 5=200mg, 6= Other
11D/CALC	OPNIDOS	Nifedipine qd 0 Dose defined* 1= None, 2= 30mg, 3= 60mg, 4= 90mg, 5= 120mg, 6= Other
15A/CALC	BLDIDOS	Dilitiazem/Placebo bid 0 Dose defined* 1= None, 2= 60mg, 3= 90mg, 4= Other
15B/CALC	BLISDOS	Isosorbide Dinitrate/Placebo bid 0 Dose defined* 1= None, 2= 20mg, 3= 40mg, 4= Other
15C/CALC	BLATDOS	Atenolol/Placebo qd 0 Dose defined* 1= None, 2= 50mg, 3= 100mg, 4= Other
15D/CALC	BLNIDOS	Nifedipine/Placebo qd 0 Dose defined* 1= None, 2= 30mg, 3= 60mg, 4= Other

* Dose = 0 defined within medical regimen assigned, if no medication taken was indicated.

Pgm. form13.sas Doc. fm13calc.wp

ACIP
CALCULATED DOSE FILE
MGDOSE.SSD01

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
CALC	BKATMG	Background Atenolol medication, mg/day
CALC	BKDIMG	Background Dilitiazem medication, mg/day
CALC	BKOPAT	Combination of open and background medication dose for Atenolol, mg/day
CALC	BKOPDI	Combination of open and background medication dose for Diltiazem mg/day
CALC	BLATMG	Blinded Atenolol mg/day
CALC	BLNIMG	Blinded Nifedipine mg/day
CALC	BLDIMG	Blinded Dilitiazem mg/day
CALC	BLISMG	Blinded Isosorbide Dinitrate mg/day
CALC	OPATMG	Open label Atenolol mg/day
CALC	OPNIMG	Open label Nifedipine mg/day
CALC	OPDIMG	Open label Dilitiazem mg/day
CALC	OPISMG	Open label Isosorbide Dinitrate mg/day
CALC	TOTAT	Total active Atenolol mg/day
CALC	TOTDI	Total active Dilitiazem mg/day
CALC	TOTIS	Total active Isosorbide Dinitrate mg/day
CALC	TOTNI	Total active Nifedipine mg/day

Pgm. mgdose.sas Doc. mgdose.wp

ACIP
FORM 14
SUBSEQUENT HOSPITALIZATION FORM
FM14.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
	VISDAYS	Days from enrollment to admission date
	DISDAYS	Days from enrollment to discharge date
		Code for Items 7A - 7G 1= Definite, 2= No, 3= Suspect
7A	MIHOSP	MI event during this hospitalization
7B	ANGHOSP	Angina event during this hospitalization
7c	CHFHOSP	CHF event during this hospitalization
7D	ARRHHOSP	Arrhythmia during this hospitalization
7E	STRKHOSP	Stroke during this hospitalization
7F	PROCHOSP	Cardiovascular procedure during hospitalization
7G	OTHHOSP	Other procedure during hospitalization
		Code for Items 8A - 8E 1= Yes, 2= No
8A1	ANGIO	Coronary angiography performed
8B1	PTCA	PTCA performed
8C1	CABG	CABG performed
8D1	INTER	Other cardiac revascularization interventional technique
8E1	SURG	Heart surgery other than CABG
CALC	HOSPSTAY	Length of hospital stay in days

Note: One record per event,
May have multiple records per patient.

Doc. form14.wp

ACIP
FORM 25
CABG SURGERY FORM
FM25.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to date of surgery
4		Check all reasons for revascularization: Code for Items 4A - 41 1= Yes, 2= No
4A	MIPROC	MI
4B	ANGPROC	Unstable angina
4c	CCSCPROC	Canadian Cardiovascular Society Class III or IV angina
4D	ECGPROC	Severe ischemic response on exercise ECG
4E	PTCAPROC	Failed PTCA
4F	ANATPROC	Coronary anatomy
4G	PHYSPROC	Decision of personal physician
4H	CLINPROC	Clinical decision not specified by protocol
41	OTHPROC	Other reason
5	PRIORITY	Surgical priority 1= Urgent, 2= Elective
6	ANGSTAT	Angina1 status at time of surgery 1= None, 2= Stable, 3= Unstable, 4= Acute MI
7A1- 7E1	SEGCODEA- SEGCODEE	Segment code (See ACIP Coronary Artery Diagram)
7A2- 7E2	CONDUITA- CONDUITE	Conduit Used A= Saphenous vein(s) B= Left internal mammary artery C= Right internal mammary artery D= Other

FORM 25 (Continued)

7A3- 7E3	QUALA- QUALE	Quality of distal vessel 1= Normal 2= Mild, diffuse, intimal thickening or plague formation 3= Moderate, diffuse, intimal thickening or plague formation with some luminal compromise 4= Severe, diffuse, intimal thickening with significant luminal compromise 5= Endarterectomy 8= Not available
7A4- 7E4	CONFIGA- CONFIGE	Configuration 1= Side to side 2= End to side 3= Individual
8	GRAFTTOT	Total number of bypass grafts
9	COND_TOT	Total number of conduits used
10	CABGTIME	Were other procedures done at time of CABG? 1= Yes, 2= No
10A	LVENTANE	Left ventricular aneurysm dissection? 1= Yes, 2= No
10B	VALVPROC	Valve procedure 1= Yes, 2= No
10B1	REPAIR	Repair 1= Yes, 2= No
10B2	REPLACE	Replace 1= Yes, 2= No
10C	OTH_CABG	Other 1= Yes, 2= No
11	NO-GRAFT	Any intended vessels not grafted? 1= Yes, 2= No
11A1	DSC1	Distal site code of intended vessel not grafted
11A2	DSC2	Distal site code of intended vessel not grafted
12	MAJOREVT	Any major events prior to discharge after surgery 1= Yes, 2= No, 3= Unknown
		Code for Items 12A - 12V 1= Did not occur 2= Occurred in operating room 3= Occurred within 24 hours 4= Occurred prior to discharge more than 24 hours after surgery
12A	DTHCABG	Death
12B	CACABG	Non-fatal cardiac arrest
12C	MICABG	Suspected non-fatal MI
12D	CHFCABG	CHF isolated or pulmonary edema (cardiac)
12E	SHKCABG	Cardiogenic shock
12F	TAMPCABG	Cardiac tamponade

FORM 25 (Continued)

12G	EMBCABG	Arterial embolus of extremity or loss of pulse requiring treatment
12H	DISSCAHG	Hypotension requiring treatment
121	ARRYCABG	Arrhythmia requiring continued therapy
12J	TIACAHG	Transient ischemic attack
12K	STRKCABG	Stroke
12L	COMACABG	Coma
12M	ALLGCABG	Hypersensitivity reaction
12N	ARDSCAHG	Respiratory failure
120	PECABG	Pulmonary embolus
12P	RENLCABG	Renal failure requiring dialysis
12Q	REOPCAHG	Re-operation for bleeding
12R	DEHICABG	Wound dehiscence
12s	INFCAHG	Mediastinitis or wound infection
12T	HEMOCAHG	Surgical hemmorrhage
12u	GICABG	Gastrointestinal hemmorrhage
12v	OTHCAHG	Other events
13	PTCOND	Condition of patient leaving operating room 1= Stable, 2= Unstable, 3= Deceased
15	OUTCOME	Good immediate outcome 1= Yes, 2= No

ACIP
FORM 43 SUSPECTED ISCHEMIC EVENT
CLASSIFICATION FORM
FM43.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
2	VISDAYS	Days from enrollment to visit date
4D	**CLASSEVT**	Classification of event: 1= MI, 2= Other ischemic event, 3= No ischemic event

Note: One record per event,
May have multiple records per patient.

Doc. form43.wp

ACIP
FORM 44
HOSPITALIZATION CLASSIFICATION FORM
FM44.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
2	VISDAYS	Days from enrollment to visit date
4	ISCHEVT	IS an ischemic event suspected? 1= Yes, 2= No

Note: One record per event,
May have multiple records per patient.

Doc. form44.wp

ACIP
FORM 66
BASELINE FORM FOR ANGIOGRAPHIC ANCILLARY STUDIES
FM66.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
3	MIHIST	History of MI 1= Yes, 2= No, 3= Unknown
4	CHF	History of CHF 1= Yes, 2= No, 3= Unknown
4A	CHFCLASS	Current functional classfication 1= One, 2= Two, 3= Three, 4= Four, a= Unknown
5	SMOKER	History of cigarette smoking 1= Yes, 2= No, 8= Unknown
5A	CURSMOKE	Current smoker (within 4 weeks) 1= Yes, 2= No
6	CADB55	Family history of CAD 1= Yes, 2= No, 3= Unknown
7	HPT	History of hypertension requiring medical treatment 1= Yes, 2= No, 3= Unknown
a	DIABETES	History of diabetes 1= Yes, 2= No, 3= Unknown
8A	DIABRX	Current therapy for diabetes 1= Oral medical, 2= Insulin, 3= Neither, 4= Both
9	HICHOL	History of hypercholesterolemia 1= Yes, 2= No, 3= Unknown
9A	HICHLVL	Recent cholesterol level 1= Yes, 2= No
9A1	HCHMG	Cholesterol level mg/dl
9A2	HCHMMOL	Cholesterol level mMol/l
10A	STROKE	Cerebrovascular accident, transient ischemic attach or carotid surgery 1= Yes, 2= No, 3= Unknown
10B	PVD	Peripheral vascular disease 1= Yes, 2= No, 3= Unknown
10C	ASTHMA	Asthma 1= Yes, 2= No, 3= Unknown
10D	BRONCH	Chronic bronchitis 1= Yes, 2= No, 3= Unknown
11	HXPROC	Any prior cardiovascular procedures 1= Yes, 2= No, 8= Unknown
11A	PTCA	PTCA 1= Yes, 2= No, 3= Unknown

FORM 66 (Continued)

11B	OTHRTECH	Other cardiac revascularization interventional technique 1= Yes, 2= No, 3= Unknown
11C	HTSURG	Heart surgery other than CABG 1= Yes, 2= No, 3= Unknown

ACIP
EVENTS FILE
Forms (6A, 14., 15., 23., 25., 43., 44)
EVENT.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
DEAD	Death 1= Yes, 0= No
DDAYS	Days from enrollment date to death (Form 15)
HOSP	Hospitalized 1= Yes, 0= No
HOSPDAYS	Days from enrollment to first hospitalization (Form 14)
HPIE	Hospitalized for ischemic event 1= Yes, 0= No (Form 44 Item 4=1)
HPIEDAYS	Days from enrollment to first hospitalized ischemic event (Form 44)
IE	Suspect ischemic event 1= Yes, 0= No
IEDAYS	Days from enrollment to first suspect ischemic event (Form 23)
MMIE	Ischemic Event Documented by MMCC (Form 43) CLASSEVT = 1 or 2 1= Yes, 0= No
MMIEDAYS	Days from enrollment to first ischemic event documented by MMCC. (Form 43)
CABG	CABG 1= Protocol CABG 2= Event CABG 0= None
CABGDAYS	Days from enrollment to first CABG (Form 25)
PTCA	PTCA 1= Protocol PTCA 2= Event PTCA 0= No
PTCADAYS	Days from enrollment to first PTCA (Form 6A)
MI	MI Documented by MMCC (Form 43) CLASSEVT = 1 1= Yes, 0= No
MIDAYS	Days from enrollment to MI Documented by MMCC (Form 43)
PTCAEV	PTCA Event (not protocol procedure) 1= Yes, 0= No

EVENTS FILE (Continued)

PTCAEVDY	Days from enrollment to first PTCA event (Form 6A)
CABGEV	CABG Event (not protocol procedure) 1= Yes, 0= No
CABGEVDY	Days from enrollment date to first CAEG event (Form 25)

NOTE: 1 Record per patient

Doc. event.wp

ACIP
QV ANGINAL SYMPTOMS
CALCULATED VARIABLES
QVSYMP.SSDOl

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
CALC	ETTANG	Angina on exercise ECG or alternate test 1= Yes 2= No
CALC	QVSXW	Number of ST episodes with angina on QV AECG
CALC	STRAT03	History of angina 1= Symptomatic 2= Asymptomatic
CALC	QVSYMP	Angina symptoms based on history, QV AECG or QV ETT 1= Symptomatic 2= Asymptomatic

Pgm.= symptomnew.sas Doc.= qvsymp.wp

A C I P
ALL PATIENTS IN
REXASCULARIZATION GROUP
CALCULATED PROTOCOL PROCEDURES
PTCACABG.SSD01

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
CALC	INCLUDE	Type of protocol procedure 0= Attempted PTCA 1= PTCA 2= CABG 3= Not done 4= Pending
CALC	CABGDAYS	Days from enrollment to CABG surgery
CALC	PTCADAYS	Days from enrollment to PTCA procedure
CALC/ 6A-12 25-15	OUTCOME	Success of procedure 1= Yes, 2= No
CALC	REVASDAY	Days from enrollment to revascularization

NOTE: All patients in revascularization group

Pgm.ptcacabg.sas Doc.ptcacabg.wp

ACIP
PRIMARY END POINT
CALCULATED VARIABLES
IMPUTE.SSD01

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
CALC	IWK12EPI	WK12 number of episodes of AECG ischemia 99= Event
CALC	IMN06EPI	MN06 number of episodes of AECG ischemia 99= Event
CALC	IMN12EPI	MN12 number of episodes of AECG ischemia 99= Event
CALC	IMPWK12	WK12 primary end point 0= No episodes, no events 1= Episodes or events
CALC	IMPMN06	MN06 primary end point 0= No episodes, no events 1= Episodes or events
CALC	IMPMN12	MN12 primary end point 0= No episodes, no events 1= Episodes or events

NOTE: Variables are defined for three time periods WK12, MN06, MN12
Patients who had an event(death, myocardial infarction, or nonprotocol revascularization) prior to the 48-hour AECG or prior to the close of the window if the AECG was not performed, are counted as "event=ischemia".

Pgm. crimpute.sas Doc. impute.wp

ACIP
ACQVINV INVENTORY
ELIGALL.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
ELIGSTAT	Eligibility status missing = being evaluated 0= Pending phone 1= Eligible 2= ineligible withdrawn 3= allocated 4= returned allocation
MEDBKGRD	Medication contraindication 1= Eligible for randomization 2= A/N w/o background therapy 3= A/N with background therapy 4= D/I w/o Background therapy 5= D/I with background therapy
AECGBACK	Background medication during QV AECG 0= None 1= A/N 2= D/I

ACIP
ACFVINV INVENTORY & CALCULATED MAXVISIT
FVINV.DAT,FM131215.DAT,MAXVISIT.SDAT
FVINVNEW.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
STDYSTAT	Study status 1= Enrolled 2= Dead 3= Inactive 4= Returned
TRTGRP	Treatment strategy 1= Angina guided 2= Angina & ischemia guided 3= Revascularization
STRATUM	Stratum 1= Symptomatic 2= Asymptomatic 3= CABG
MED	Medication 1= A/N 2= D/I
STATUS	Status of patient at last follow-up. 1= Alive 2= Dead 3= Unknown
MAXVISIT	Last visit for a patient.
FUDAYS	Total number of days in study (last visdt - enrolldt) Using forms 12,13,15.
BACKGRND	Background medication 0= None 1= A/N 2= D/I

NOTE: Only included STDYSTAT=1

Doc. fvinv.wp

ACIP
AECG CORE LAB SUMMARY DATA
FINLST.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
VISIT	Visit type
EP148	Number of ischemic episodes
DUR48	Duration of ischemic episodes
LOWHR	Minimum heart rate
HIGHHR	Maximum heart rate
MEANHR	Mean heart rate
TOTSEC	Total tape duration
MAXSTD48	Maximum ST depression
SX	Number of ST episodes with no angina
SXWANG	Number of ST episodes with angina pain
MAXHR	Maximum heart rate for ischemic episodes
MINHRST	Minimum heart rate for ischemic episodes
MAXHRST	Maximum heart rate at lmm of ST depression
STPR48	Computed value which is the product of MAXSTD48 and TOTSEC
QUALITY	Tape quality value is averaged from 2 tapes 0 = Very poor quality, unprocessible 5 = Poor, processible 10= Fair > 50% artifact 15= Good, intermittent artifact or loss of signal 20= Very good 25= Excellent
HR5MPRE	Heart rate 5 minutes before the ST episode
HRBASE	Heart rate at baseline
HRAT1MM	Heart rate at 1 mm ST deviation
HRMXST	Maximum heart rate corresponding to the maximum ST depression. Missing if no episodes.

NOTE: One record for each 48 hours of recordings

Doc. stdata.wp

ACIP
SUMMARY CALCULATED AECG DATA
FINLAECG.SSD01

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
		QV = qualifying visit
CALC	QV	QV 1= Yes, missing= No
RENAME	QVIE	Ischemic episode 0= No, 1= Yes
RENAME	QVEPI	Number of ischemic episodes
RENAME	QVTIME	Number of ischemic episodes/duration of ischemic episodes
RENAME	QVDUR	Duration of ischemic episodes
RENAME	QVSEC	Total tape duration (seconds)
RENAME	QVHR	Maximum heart rate for ischemic episodes
RENAME	QVSX	Number of ST episodes with no angina
RENAME	QVSXW	Number of ST episodes with angina pain
RENAME	QVSTD	Maximum ST depression
RENAME	QVSTPR	Computed value which is the product of QVSTD and QVSEC
RENAME	QVHIHR	Maximum heart rate
RENAME	QVMNHR	Mean heart rate
		WK04 = **four-week visit**
CALC	WK04	WK04 visit 1= Yes, missing= No
RENAME	WK04IE	Ischemic episode 0= No, 1= Yes
RENAME	WK04EPI	Number of ischemic episodes
RENAME	WK04TIME	Number of ischemic episodes/duration of ischemic episodes
RENAME	WK04DUR	Duration of ischemic episodes
RENAME	WK04SEC	Total tape duration (seconds)
RENAME	WK04HR	Maximum heart rate for ischemic episodes
RENAME	WK04SX	Number of ST episodes with no angina
RENAME	WK04SXW	Number of ST episodes with angina pain
RENAME	WK04STD	Maximum ST depression

SUMMARY CALCULATED AECG DATA (continued)

RENAME	WK04STPR	Computed value which is the product of WK04STD and WK04SEC
RENAME	WK04HIHR	Maximum heart rate
RENAME	WK04MNHR	Mean heart rate
CALC	DIFFWK04	Number of ischemic episodes at WK04 - number of ischemic episodes at QV
CALC	COMPWK04	Number of ischemic episodes at WK04 compared to number of ischemic episodes at QV 1= Fewer, 2= Same, 3= More
		WK08 = Eight-week visit
CALC	WK08	WK08 visit 1= Yes, missing= No
RENAME	WK08IE	Ischemic episode 0= No, 1= Yes
RENAME	WK08EPI	Number of ischemic episodes
RENAME	WK08TIME	Number of ischemic episodes/duration of ischemic episodes
RENAME	WK08DUR	Duration of ischemic episodes
RENAME	WK08SEC	Total tape duration (seconds)
RENAME	WK08HR	Maximum heart rate for ischemic episodes
RENAME	WK08SX	Number of ST episodes with no angina
RENAME	WK08SXW	Number of ST episodes with angina pain
RENAME	WK08STD	Maximum ST depression
RENAME	WK08STPR	Computed value which is the product of WK08STD and WK08SEC
RENAME	WK08HIHR	Maximum heart rate
RENAME	WK08MNHR	Mean heart rate
CALC	DIFFWK08	Number of ischemic episodes at WK08 - number of ischemic episodes at QV
CALC	COMPWK08	Number of ischemic episodes at WK08 compared to number of ischemic episodes at QV 1= Fewer, 2= Same, 3= More

SUMMARY CALCULATED AECG DATA (continued)

		WK12 = Twelve-week visit
CALC	WK12	WK12 visit 1= Yes, missing= No
RENAME	WK12IE	Ischemic episode 0= No, 1= Yes
RENAME	WK12EPI	Number of ischemic episodes
RENAME	WK12TIME	Number of ischemic episodes/duration of ischemic episodes
RENAME	WK12DUR	Duration of ischemic episodes
RENAME	WK12SEC	Total tape duration (seconds)
RENAME	WK12HR	Maximum heart rate for ischemic episodes
RENAME	WK12SX	Number of ST episodes with no angina
RENAME	WK12SXW	Number of ST episodes with angina pain
RENAME	WK12STD	Maximum ST depression
RENAME	WK12STPR	Computed value which is the product of WK12STD and WK12SEC
RENAME	WK12HIHR	Maximum heart rate
RENAME	WK12MNHR	Mean heart rate
CALC	DIFFWK12	Number of ischemic episodes at WK12 - number of ischemic episodes at QV
CALC	COMPWK12	Number of ischemic episodes at WK12 compared to number of ischemic episodes at QV 1= Fewer, 2= Same, 3= More
		MN06 = Six-month visit
CALC	MN06	MN06 visit 1= Yes, missing= No
RENAME	MN06IE	Ischemic episode 0= No, 1= Yes
RENAME	MN06EPI	Number of ischemic episodes
RENAME	MN06TIME	Number of ischemic episodes/duration of ischemic episodes
RENAME	MN06DUR	Duration of ischemic episodes
RENAME	MN06SEC	Total tape duration (seconds)
RENAME	MN06HR	Maximum heart rate for ischemic episodes
RENAME	MN06SX	Number of ST episodes with no angina
RENAME	MN06SXW	Number of ST episodes with angina pain
RENAME	MN06STD	Maximum ST depression
RENAME	MN06STPR	Computed value which is the product of MN06STD and MN06SEC
RENAME	MN06HIHR	Maximum heart rate

SUMMARY CALCULATED AECG DATA (continued)

RENAME	MN06MNHR	Mean heart rate
CALC	DIFFMN06	Number of ischemic episodes at MN06 - number of ischemic episodes at QV
CALC	COMPMN06	Number of ischemic episodes at MN06 compared to number of ischemic episodes at QV 1= Fewer, 2= Same, 3= More
		MN12 = Twelve-month visit
CALC	MN12	MN12 visit 1= Yes, missing= No
RENAME	MN12IE	Ischemic episode 0= No, 1= Yes
RENAME	MN12EPI	Number of ischemic episodes
RENAME	MN12TIME	Number of ischemic episodes/duration of ischemic episodes
RENAME	MN12DUR	Duration of ischemic episodes
RENAME	MN12SEC	Total tape duration (seconds)
RENAME	MN12HR	Maximum heart rate for ischemic episodes
RENAME	MN12SX	Number of ST episodes with no angina
RENAME	MN12SXW	Number of ST episodes with angina pain
RENAME	MN12STD	Maximum ST depression
RENAME	MN12STPR	Computed value which is the product of MN12STD and MN12SEC
RENAME	MN12HIHR	Maximum heart rate
RENAME	MN12MNHR	Mean heart rate
CALC	DIFFMN12	Number of ischemic episodes at MN12 - number of ischemic episodes at QV
CALC	COMPMN12	Number of ischemic episodes at MN12 compared to number of ischemic episodes at QV 1= Fewer, 2= Same, 3= More

NOTE: One record for each enrolled patient.
Most variables renamed from AECG FINLST file.

Pgm.= craecg.sas Doc.= finlaecg.wp

ACIP
AECG CORE LAB EPISODE DATA
STEPISOD.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
VISIT	Visit Type
TAPEID	Code number used by AECG Core Lab
TAPEDAYS	Days from enrollment to date of recording
ONTIME	Onset time of each individual ST-segment or symptom episode (HH:MM:SS).
DURATION	Total duration of the ST episode
BASEHR	Heart rate at baseline
HRAT1MM	Heart rate at 1 mm ST deviation
MAXSTD	Maximum ST-segment deviation compared to ST-segment baseline += ST elevation -= ST depression
SYMPTOM	Indication that presence of pain during episode is inferred Y = Pain, N = No pain
STARTTM	Start time of recording (HH:MM:SS)
QUALITY	Tape quality 0= Very poor quality, unprocessible 5= Poor, processible 10= Fair, > 50% artifact 15= Good, intermittent artifact or loss of signal 20= Very good 25= Excellent
UNINTERP	Code for interpreting ST segment 0= Both channels are interpretable 11= 1 channel not interpretable due to excessively abnormal ST morphology 12= 1 channel not interpretable due to poor technical recording 21= 2 channels not interpretable due to excessively abnormal ST morphology. 22= 2 channels not interpretable due to poor technical recording.
HR5MPRE	Heart Rate 5 minutes before the ST episode
HR2MPRE	Heart Rate 2 minutes before the ST episode
HRDELTA	Difference between the HR 5 minutes before the episode, compared to the HR at onset of episode.

NOTE: 1 Record for each episode
QV only

Doc. stepisode.wp

ACIP
AECG CORE LAB ARRHYTHMIA
SUMMARY DATA
ARRHY.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
VISIT	Visit Type
TAPEID	Code number used by AECG Core Lab
TAPEDAYS	Days from enrollment to date of recording
VPBHIGH	Ventricular premature beats high in any interval
VPBMEAN	Ventricular premature beats mean
VPBSTDEV	Ventricular premature beats standard deviation
VPBTOT	Total ventricular premature beats
VPBHTB	VPB/1000 heart beats
HOURS	Time analysed in hours
VPBPAIR	VPB paired
VTEVENT	Ventricular events
RTBEATS	R on T beats
MULTFRM	Multiform (Y,N)
TOTVT3	Total ventricular runs of 3 beats
TOTVT4	Total ventricular runs of 4 beats
TOTVT5	Total ventricular runs of 5 beats
TOTVT6	Total ventricular runs of 6-9 beats
TOTVT10	Total ventricular runs of 10+ beats
TOTSVT3	Total SVT runs of 3 beats
TOTSVT4	Total SVT runs of 4 beats
TOTSVT5	Total SVT runs of 5 beats
TOTSVT6	Total SVT runs of 6-9 beats
TOTSVT10	Total SVT runs of 10+ beats

AECG CORE LAB ARRHYTHMIA
SUMMARY DATA (Continued)

	RHYTHM TYPE
SINUS	Sinus 0= Absent, 1= Present
AFLUT	Atria1 Flutter 0= Absent, 1= Present
AFIB	Atria1 Fibrillation 0= Absent, 1= Present
BLOCK1	1st Degree Block 0= Absent, 1= Present
BLOCK2	2nd Degree Block 0= Absent, 1= Present
BLOCK3	3rd Degree Block 0= Absent, 1= Present
PACED	Paced 0= Absent, 1= Present
OTHER	Other 0= Absent, 1= Present
NODAL	Nodal 0= Absent, 1= Present
IVENT	Idioventricular 0= Absent, 1= Present
AVENT	Accelerated Ventricular 0= Absent, 1= Present
JUNCT	Junctional 0= Absent, 1= Present

NOTE: 1 record for each 24-hour tape

Doc. arrhy.wp

ACIP
RESTING ECG CORE LAB DATA
MINNESOTA CODE
ECGREST.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
VISIT	Visit type
ARRHY	Arrhythmias
AVCOND	A-V Conduction Defects
VENTCOND	Ventricular Conduction Defects RBBB= 21 or 8 IVCD= 4
	MINNESOTA QWAVE CODES lx, 2x, 3x
QCLAT	Q-Codes Lateral
QCINF	Q-Codes Inferior
QCANT	Q-Codes Anterior
	MINNESOTA ST CODES Major= lx Minor= 2, 3, 4
STDLAT	ST-Depression Lateral
STDINF	ST-Depression Inferior
STDANT	ST-Depression Anterior
	MINNESOTA T WAVE CODES Major= 1, 2, 5, 6 Minor= 3, 4
WTLAT	T Wave Lateral
TWINF	T Wave Inferior
TWANT	T Wave Anterior
HYPER	Left Ventricular Hypertrophy LVH= 1
STELAT	ST-Elevation Lateral
STEINF	ST-Elevation Inferior
STEANT	ST-Elevation Anterior

RESTING ECG CORE LAB DATA (Continued)

	MI	Myocardial Infarction 0= No MI 1= Definite MI 2= Probable MI 3= Possible MI -1= Missing ECG
	ISCH	Ischemic Event 0= No Ischemia 1= Definite Ischemia 2= Probable Ischemia 3= Possible Ischemia -1= Missing ECG
	NOCHANGE	No Change/No MI 0= No 1= Yes
	TECHPOOR	0 or blank= No 1= Yes 2= Torso ECG (can still evaluate but lead placement is not standard)
CALC	RBBB	Right bundle branch block
CALC	IVCD	Intra ventricular conduction defect
CALC	LVH	Left ventricular hypertrophy
CALC	QWAVE	Q-wave criterion
CALC	STD	ST depression
CALC	MAJSTD	Major ST depression
CALC	MINSTD	Minor ST depression
CALC	TWAVE	T wave criterion
CALC	MAJT	Major T wave
CALC	MINT	Minor T wave
CALC	NORMAL	1= Normal Rest ECG 0= Abnormal Rest ECG

NOTE: Invalid or suppressed codes indicated by -2

Doc. ecgrest.wp

ACIP
ETT CORE LAB DATA
ETTECGX.SSD01

VARIABLE NAME	CODES
NEWID	Patient id
VISIT	Visit type
EADDESC	Lead descriptor 1= Standard lead where measured 2= Bipolar lead where measured
ECGDESC	ECG descriptor 0= No exclusions 1= Leads V5 and/or V6 may be measured only - ECG showed Right Bundle Branch Block 2= All leads may be measured but ECG showed Left Ventricular Hypertrophy 3= Leads not measured -No change 4= No leads measured - Left Bundle Branch Block 5= No leads measured due to Wolff/Parkinson/White Syndrome 6= No leads measured due to exercise induced left Bundle Branch Block 7= No leads measured due to exercise induced Right Bundle Branch Block 8= No leads measured due to excess artifact/ technically poor tracing 9= No leads measured due to missing data/ECG 10= No leads measured due to Ventricular Pacemaker 11= No leads measured due to Ventricular Tachycardia/Fibrillation 12= No leads measured due to Supraventricular Tachycardia
	AB LEAD Codes for Standard/Bipolar Leads 1= Normal ST segment (includes visual inspection) 2= Abnormal ST segment depression (downsloping or horizontal) 3= Abnormal ST segment depression (upsloping) 4= Abnormal non-Q wave ST segment elevation 5= Q wave ST segment elevation -1= No data for individual lead only -2= Not applicable (measurement suppressed or nonapplicable lead position for the corresponding Right Bundle Branch Block or Bipolar lead)
ICC5	Standard/Bipolar Lead
V1CM5	Standard/Bipolar Lead

ETT CORE LAB DATA (Continued)

V4MCL	Standard/Bipolar Lead
II	Standard/Bipolar Lead
AVL	Standard/Bipolar Lead
v2	Standard/Bipolar Lead
V5	Standard/Bipolar Lead
III	Standard/Bipolar Lead
AVP	Standard/Bipolar Lead
v3	Standard/Bipolar Lead
V6	Standard/Bipolar Lead
NBRLEADS	Number of leads measured including visual inspection leads. -2 means not applicable.
BADLEADS	Number of leads measured found to have abnormal End Point Criteria. -2 means not applicable.
MISLEADS	Number of individual leads missing data.
MAXSTDEP	Maximum ST segment depression
MAXSTEL	Maximum ST segment elevation
ECMIN	Time to recovery (minutes)
VTACH	Ventricular Tachycardia 1= Yes, 2= No, 3= Unknown
VFIB	Ventricular Fibrillation 1= Yes, 2= No, 3= Unknown

ETT CORE LAB DATA (Continued)

ENDPT	0= Not met for any leads measured 1= J point depression >= 0.1 mV, ST segment horizontal or downward, slope c 1 mV/second, ST-80 depression >= 0.1mV, or ST-80 depression >= 0.15 mV, ST segment upward slope >1 mV/second 2= J point depression >= 0.25 mV, ST segment horizontal or downward slope c 1 mV/second, ST-80 depression >= 0.25 mV after 8 minutes exercise, or ST-80 depression >= 0.3 mV, ST segment upward slope >= 1 mV/second after 8 minutes exercise, or J point elevation >= 0.2 mV, ST-80 elevation >= 0.2mV in a non-infarct related territory after 8 minutes exercise 3= J point depression >= 0.25 mV, ST segment horizontal or downward slope < 1 mV/second, ST-80 depression >= 0.25 mV before 8 minutes exercise, or ST-80 depression >= 0.3 mV, ST segment upward slope >= 1 mV/second before 8 minutes exercise, or J point elevation >= 0.2 mV, ST-80 elevation >= 0.2mV in a non-infarct related territory before 8 minutes exercise
STON	Time(seconds) to 1.0 mm of ST segment change
STOFF	Time in recovery (seconds) to c 1.0 mm of ST segment change
RECOVERY	Did onset of ST changes occur in recovery. Y= Occurred in recovery N= Occurred in exercise
STLATSUM	Total ST depression in lateral leads.
STINFSUM	Total ST depression in inferior leads
STANTSDM	Total ST depression in anterior leads
STTOTAL	Total ST depression in all abnormal leads
STHRINDX	ST/RR Index
STSUM05	Total ST depression in all leads

ACIP
QV CALCULATED ETT DATA
ETTQV.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
8E/2	VISDAYS	Days from enrollment to exercise tolerance test date (missing if ETT not done)
CALC	ALTETT	1= Alternate QV Stress Test
CALC	**ANGHR**	Heart rate at onset of angina
CALC	ANGMIN	Minutes to onset of angina
CALC	ANGSBP	Systolic BP at onset of angina
CALC	ANGSTGE	Stage at onset of angina 1 - 10= During exercise 20 - 26= During recovery 20= Immediate recovery 21= Recovery minute 1 22= Recovery minute 2 23= Recovery minute 3 24= Recovery minute 4 25= Recovery minute 5 26= Recovery prolonged
ETTECG	**BADLEADS**	Number of abnormal leads
ETTECG	ENDPT	See documentation for ETT Core Lab data on ETTECGX file
8E/12	ETTANG	Did angina occur during study? 1= Yes, 2= No, 3= Uncertain
CALC	ETTMIN	Total minutes of exercise
8E/8A	ETTPRIM	See documentation for Form 8E
8E/7A	ETTPROT	Protocol description 1= Standard ACIP 2= Modified ACIP
8E/CALC	FINDBP	Final stage diastolic BP value
8E/CALC	FINHR	Final stage heart rate value
8E/CALC	FINRPE	Final stage RPE value
8E/CALC	FINSBP	Final stage systolic BP value
8E/7C	FINSTGE	Final stage of exercise entered

QV CALCULATED ETT DATA (continued)

ETTECG	MAXSTDEP	Maximum ST segment depression
ETTECG	MISLEADS	Number of leads missing data
ETTECG	NBRLEADS	Number of leads measured including visual inspection leads.
ETTECG	RECOVERY	Did onset of ST changes occur in recovery? Y= Yes N = No
CALC	STHR	HR at onset of ST depression >= 1mm
ETTECG	STHRINDX	ST/HR Index
CALC	STMIN	Minutes to ST depression >= 1mm
CALC	STSBP	SBP at onset of ST depression >= 1mm
CALC	STSTGE	Stage at onset of ST depression >= lmm (See ANGSTGE for codes)
ETTECG	STSUM05	Total ST depression in all leads
ETTECG	STTOTAL	Total ST depression in abnormal leads
ETTECG	VFIB	Ventricular Fibrillation 1= Yes, 2= No, 3= Unknown
ETTECG	VTACH	Ventricular Tachycardia 1= Yes, 2= No, 3= Unknown
CALC	WORKLOAD	Workload, METS

NOTE: Includes core lab and clinic data for procedures performed
Source = Clinic Form 8E or ETTECG file or calculated

Pgm. = ETT.SAS Doc. = ETTQV.WP

ACIP
WK12 CALCULATED ETT DATA
ETTWK12.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
8E/2	VISDAYS	Days from enrollment to exercise tolerance test date
CALC	ANGHR	Heart rate at onset of angina
CALC	ANGMIN	Minutes to onset of angina
CALC	ANGSBP	Systolic BP at onset of angina
CALC	ANGSTGE	Stage at onset of angina 1 - 10= During exercise 20 - 26= During recovery 20= Immediate recovery 21= Recovery minute 1 22= Recovery minute 2 23= Recovery minute 3 24= Recovery minute 4 25= Recovery minute 5 26= Recovery prolonged
ETTECG	BADLEADS	Number of abnormal leads
ETTECG	ENDPT	See documentation for ETT Core Lab data on ETTECGX file
8E/12	ETTANG	Did angina occur during study? 1= Yes, 2= No, 3= Uncertain
CALC	ETTMIN	Total minutes of exercise
8E/8A	ETTPRIM	See documentation for Form 8E
8E/7A	ETTPROT	Protocol description 1= Standard ACIP 2= Modified ACIP
8E/CALC	FINDBP	Final stage diastolic BP value
8E/CALC	FINHR	Final stage heart rate value
8E/CALC	FINRPE	Final stage RPE value
8E/CALC	FINSBP	Final stage systolic BP value
8E/7C	FINSTGE	Final stage of exercise entered
ETTECG	MAXSTDEP	Maximum ST segment depression

WK12 CALCULATED ETT DATA (continued)

ETTECG	MISLEADS	Number of leads missing data
ETTECG	NBRLEADS	Number of leads measured including visual inspection leads.
ETTECG	RECOVERY	Did onset of ST changes occur in recovery? Y= Yes N = No
CALC	STHR	HR at onset of ST depression >= 1mm
ETTECG	STHRINDX	ST/HR Index
CALC	STMIN	Minutes to ST depression >= 1mm
CALC	STSBP	SBP at onset of ST depression >= 1mm
CALC	STSTGE	Stage at onset of ST depression >= 1mm (See ANGSTGE for codes)
ETTECG	STSUM05	Total ST depression in all leads
ETTECG	STTOTAL	Total ST depression in abnormal leads
ETTECG	VFIB	Ventricular Fibrillation 1= Yes, 2= No, 3= Unknown
ETTECG	VTACH	Ventricular Tachycardia 1= Yes, 2= No, 3= Unknown
CALC	WORKLOAD	Workload, METS

NOTE: Includes core lab and clinic data for procedures performed
Source = Clinic Form 8E or ETTECG file or calculated

ACIP
MN06 CALCULATED ETT DATA
ETTMN06.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
8E/2	VISDAYS	Days from enrollment to exercise tolerance test date
CALC	ANGHR	Heart rate at onset of angina
CALC	ANGMIN	Minutes to onset of angina
CALC	ANGSBP	Systolic BP at onset of angina
CALC	ANGSTGE	Stage at onset of angina 1 - 10= During exercise 20 - 26= During recovery 20= Immediate recovery 21= Recovery minute 1 22= Recovery minute 2 23= Recovery minute 3 24= Recovery minute 4 25= Recovery minute 5 26= Recovery prolonged
ETTECG	BADLEADS	Number of abnormal leads
ETTECG	ENDPT	See documentation for ETT Core Lab data on ETTECGX file
8E/12	ETTANG	Did angina occur during study? 1= Yes, 2= No, 3= Uncertain
CALC	ETTMIN	Total minutes of exercise
8E/8A	ETTPRIM	See documentation for Form 8E
8E/7A	ETTPROT	Protocol description 1= Standard ACIP 2= Modified ACIP
8E/CALC	FINDBP	Final stage diastolic BP value
8E/CALC	FINHR	Final stage heart rate value
8E/CALC	FINRPE	Final stage RPE value
8E/CALC	FINSBP	Final stage systolic BP value
8E/7C	FINSTGE	Final stage of exercise entered
ETTECG	MAXSTDEP	Maximum ST segment depression

MN06 CALCULATED ETT DATA (continued)

ETTECG	MISLEADS	Number of leads missing data
ETTECG	NBRLEADS	Number of leads measured including visual inspection leads.
ETTECG	RECOVERY	Did onset of ST changes occur in recovery? Y= Yes N = No
CALC	STHR	HR at onset of ST depression >= 1mm
ETTECG	STHRINDX	ST/HR Index
CALC	STMIN	Minutes to ST depression >= 1mm
CALC	STSBP	SBP at onset of ST depression >= lmm
CALC	STSTGE	Stage at onset of ST depression >= lmm (See ANGSTGE for codes)
ETTECG	STSUM05	Total ST depression in all leads
ETTECG	STTOTAL	Total ST depression in abnormal leads
ETTECG	VFIB	Ventricular Fibrillation 1= Yes, 2= No, 3= Unknown
ETTECG	VTACH	Ventricular Tachycardia 1= Yes, 2= No, 3= Unknown
CALC	WORKLOAD	Workload, METS

NOTE: Includes core lab and clinic data for procedures performed
Source = Clinic Form 8E or ETTECG file or calculated

ACIP
MN12 CALCULATED ETT DATA
ETTMN12.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
8E/2	VISDAYS	Days from enrollment to exercise tolerance test date
CALC	ANGHR	Heart rate at onset of angina
CALC	ANGMIN	Minutes to onset of angina
CALC	ANGSBP	Systolic BP at onset of angina
CALC	ANGSTGE	Stage at onset of angina 1 - 10= During exercise 20 - 26= During recovery 20= Immediate recovery 21= Recovery minute 1 22= Recovery minute 2 23= Recovery minute 3 24= Recovery minute 4 25= Recovery minute 5 26= Recovery prolonged
ETTECG	BADLEADS	Number of abnormal leads
ETTECG	ENDPT	See documentation for ETT Core Lab data on ETTECGX file
8E/12	ETTANG	Did angina occur during study? 1= Yes, 2= No, 3= Uncertain
CALC	ETTMIN	Total minutes of exercise
8E/8A	ETTPRIM	See documentation for Form 8E
8E/7A	ETTPROT	Protocol description 1= Standard ACIP 2= Modified ACIP
8E/CALC	FINDBP	Final stage diastolic BP value
8E/CALC	FINHR	Final stage heart rate value
8E/CALC	FINRPE	Final stage RPE value
8E/CALC	FINSBP	Final stage systolic BP value
8E/7C	FINSTGE	Final stage of exercise entered
ETTECG	MAXSTDEP	Maximum ST segment depression

MN12 CALCULATED ETT DATA (continued)

ETTECG	MISLEADS	Number of leads missing data
ETTECG	NBRLEADS	Number of leads measured including visual inspection leads.
ETTECG	RECOVERY	Did onset of ST changes occur in recovery? Y= Yes N = No
CALC	STHR	HR at onset of ST depression >= 1mm
ETTECG	STHRINDX	ST/HR Index
CALC	STMIN	Minutes to ST depression >= 1mm
CALC	STSBP	SBP at onset of ST depression >= 1mm
CALC	S T S T G E	Stage at onset of ST depression >= lmm (See ANGSTGE for codes)
ETTECG	STSUM05	Total ST depression in all leads
ETTECG	STTOTAL	Total ST depression in abnormal leads
ETTECG	VFIB	Ventricular Fibrillation 1= Yes, 2= No, 3= Unknown
ETTECG	VTACH	Ventricular Tachycardia 1= Yes, 2= No, 3= Unknown
CALC	WORKLOAD	Workload, METS

NOTE: Includes core lab and clinic data for procedures performed
Source = Clinic Form 8E or ETTECG file or calculated

ACIP
FORM 7F ANGIOGRAPHY CORE LAB DATA
FM7FANG.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
2	VISDAYS	Days from enrollment to date of angiogram
3		Angiogram Type Code for Items 3A - 3C 1= Yes
3A	QVANG	Qualifying
3B	CONFANG	Confirmation of anatomy prior to protocol revascularization
3c	PTCAANG	Protocol PTCA
4	ANGQUAL	Quality 1= Superior, 2= Satisfactory 3= Unsatisfactory, 4= Uninterpretable
4A	ANGWAS	This coronary angiogram was 1= Suboptimal, 2= Rejected, 3= Incomplete
		Indicate reason for poor quality film Code for Items 4B - 4G 1= Yes
4B	BADFILM	Image film quality too poor to permit analysis
4c	LESOBS	Lesion(s) obscured by overlaying branch arteries
4D1	HIGHMAG	The entire artery not visualized too high magnification
4D2	COLLIM	The entire artery not visualized excess collimation
4D3	PANNING	The entire artery not visualized inappropriate panning
4E	SLOWRATE	Injection rate too slow
4F	INCPROJ	Incorrect projection
4G	OTHR	Other reason

NATIVE SEGMENT ASSESSMENT

5A1- 5H1	ANGSITEA- ANGSITEH	Site Codes 01-29 (See ACIP Coronary Artery Diagram) Site code 30= Other

FORM 7F ANGIOGRAPHY CORE LAB DATA (Continued)

5A2-	ANGPERFA-	Perfusion Grade
5H2	ANGPERFH	Values= 0-3, 8= Not available
5A3- 5H3	ANGSTENA- ANGSTENH	% Stenosis
5A4- 5H4	ANGCOLLA- ANGCOLLH	Collateral 0= None, 1= Partial, 2= Complete, 8= Not available
5A5- 5H5	ANGCONTA- ANGCONTH	Stenosis Contour 0= Smooth lumen borders 1= Ill-defined borders 2= Irregular lumen borders 8= Not available
5A6- 5H6	ANGULCA- ANGULCH	Ulcer Grade 0= None, 1= Possible ulcer, 2= Definite ulcer, 8= Not available
5A7- 5H7	ANGTHRMA- ANGTHRMH	Thrombus Grade 0= None 1= Possible 2= <= 1/2 linear dimension vessel diameter 3= >1/2 but < 2 vessel diameters in size 4= >= 2 vessel diameter in size 8= Not available
5A8 5H8	ANGECCA- ANGECCH	Eccentric or Concentric Values= E or C 8= Not available

BYPASS GRAFTS ASSESSMENT

6A1- 6H2	GRFSITEA- GRFSITEH	Site code First site code in positions 1 and 2 second site code in positions 3 and 4 2 site codes supplied = jump graft first site code is XX = veingraft to second site code
6A2- 6H2	GRFSVGA- GRFSVGH	1= SVG, 2=IMA
6A3- 6H3	GRFGT50A- GRFGT50H	Stenosis >= 50% 1= Yes, 2= No, 3= Not assessed
6A4- 6H4	GRFLOCA- GRFLOCH	Location P= Proximal, M= Mid, D= Distal, A= Distal Anastomosis
6A5- 6H5	GRFPERFA- GRFPERFH	Perfusion grade Values= 0-3
6A6- 6H6	GRFSTENA- GRFSTENH	% Stenosis
6A7- 6H7	GRFCONTA- GRFCONTH	Stenosis contour (See Items 5A5 - 5H5 Codes))
6A8- 6H8	GRFULCA- GRFULCH	Ulcer grade (See Items 5A6 - 5H6 Codes))

FORM 7F ANGIOGRAPHY CORE LAB DATA (Continued)

6A9- 6H9	GRFTHRMA- GRFTHRMB	Thrombus grade (See Items 5A7 - 5H7 Codes)
6A10- 6H10	GRFECCA- GRFECCH	Eccentric or Concentric Values= E or C
7	GT50STEN	>= 50% stenosis in a major native vessel or bypass graft 1= Yes, 2= No, 8= Not available
8A	GT50LM	>= 50% left main coronary artery stenosis 1= Yes, 2= No, 8= Not available
8B	MITRAL	Significant mitral regurgitation 1= Yes, 2= No, 8= Not available
8C	OTHEXC	Other angiographic exclusion criteria 1= Yes, 2= No, 8= Not available
9	ANGELIG	Does this cineangiogram meet ACIP eligibility criteria? 1= Yes, 2= No, 8= Not available
		ASSESSMENT OF VENTRICULOGRAM
19B	EJFR	Global ejection fraction 9.98= Not available
19C	RAOPNA	RAO projection not available 1= Not available
		Codes for Items 19C1 to 19C5 and 19D6 - 19D10 1= Normal, 2= Hypokinetic, 3= Dyskinetic, 4= Akinetic, 5= Not assessed
19C1	ANTBASAL	Anterobasal
19C2	ANTLATER	Anterolateral
19C3	APICAL	Apical
19C4	DIAPHRAG	Diaphragmatic
19C5	POSBASAL	Posterobasal
19D	LAOPNA	LAO projection not available 1= Not available
19D6	BASSEPT	Basal septal
19D7	APISEPT	Apical septal
19D8	POSLATER	Posterolateral
19D9	INFLATER	Inferior lateral
19D10	SUPLATER	Superior lateral

ACIP
FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
QV7FNEW.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
7F/2	VISDAYS	Days from enrollment to date of angiogram
		NATIVE SEGMENT ASSESSMENT
5A1- 5H1	ANGSITEA- ANGSITEH	Site code Codes= 01-29 (See ACIP Coronary Artery Diagram) Site code 30= Other
5A2- SH2	ANGPERFA- ANGPERFH	Perfusion Grade Values= 0-3, 8= Not available
5A3- SH3	ANGSTENA- ANGSTENH	% Stenosis
5A4- 5H4	ANGCOLLA- ANGCOLLH	Collateral 0= None, 1= Partial, 2= Complete, 8= Not available
5A5- 5H4	ANGCONTA- ANGCONTH	Stenosis Contour 0= Smooth lumen borders 1= Ill-defined borders 2= Irregular lumen borders 8= Not available
5A6- 5H6	ANGULCA- ANGULCH	Ulcer Grade 0= None, 1= Possible ulcer, 2= Definite ulcer, 8= Not available
5A7- 5H7	ANGTHRMA- ANGTHRMH	Thrombus Grade 0= None 1= Possible 2= <= 1/2 linear dimension vessel diameter 3= >1/2 but c 2 vessel diameters in size 4= >= 2 vessel diameter in size 8= Not available
5A8 5H8	ANGECCA- ANGECCH	Eccentric or Concentric Values= E or C 8= Not available
7	GTSOSTEN	>= SO% stenosis in a major native vessel or bypass graft 1= Yes, 2= No, 8= Not available
8A	GT50LM	>= SO% left main coronary artery stenosis 1= Yes, 2= No, 8= Not available
8B	MITRAL	Significant mitral regurgitation 1= Yes, 2= No, 8= Not available

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA (continued)

8C	OTHEXC	Other angiographic exclusion criteria 1= Yes, 2= No, 8= Not available
9	ANGELIG	Does this cineangiogram meet ACIP eligibility criteria? 1= Yes, 2= No, 8= Not available
19B	EJFR	Global ejection fraction 9.98= Not available
		Codes for Items 19C1 - C5 and 19D6 - D10 1= Normal, 2= Hypokinetic, 3= Dyskinetic, 4= Akinetic, 5= Not assessed
19C1	ANTBASAL	Anterobasal
19C2	ANTLATER	Anterolateral
19C3	APICAL	Apical
19C4	DIAPHRAG	Diaphragmatic
19C5	POSBASAL	Posterobasal
19D6	BASSEPT	Basal septal
19D7	APISEPT	Apical septal
19D8	POSLATER	Posterolateral
19D9	INFLATER	Inferior lateral
19D10	SUPLATER	Superior lateral
CALC	AVESTEN	Average stenosis
CALC	MAXSTEN	Worst stenosis
CALC	NCOMPLAQ	Number of lesions with definite complex plague
CALC	NG1ULCER	Number of lesions grade 1 ulcer
CALC	NG2ULCER	Number of lesions grade 2 ulcer
CALC	NGRADE1	Number of lesions grade 1+ thrombus, ulcer, contour
CALC	NOCCOL	Number of lesions totally occluded, grade 1,2 collateral
CALC	NOCNOCOL	Number of lesions totallv occluded, grade 0 collateral
CALC	NOVES	Number of vessels >= 50% stenosis Values = 1 - 3
CALC	NPERFLE2	Number of lesions, perfusion grade 0 - 2

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA (continued)

CALC	NS100T0	Number of lesions stenosis = 100%, perfusion grade = 0
CALC	NS95TLE2	Number of lesions stenosis >= 95%, perfusion grade le 2
CALC	NS95_G12	Number of lesions stenosis >= 95%, perfusion grade 1 or 2
CALC	NS99TLE1	Number of lesions stenosis >= 99%, perfusion grade le 1
CALC	NSITE	Number of of lesions measured
CALC	NSTEN50	Number of lesions, > = 50% stenosis
CALC	NSTEN95	Number of lesions, > = 95% c 100% stenosis
CALC	NTHRMGE2	Number of lesions grade 2+ thrombus
CALC	NTOTOCC	Number of totally occluded lesions
CALC	PROXGE50	1= > = 50% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PROXGE70	1= > = 70% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PRXLAD50	1= > = 50% stenosis, prox LAD, 0 otherwise
CALC	PRXLAD70	1= > = 70% stenosis, prox LAD, 0 otherwise
CALC	STENCX	1= CX stenosis > = 50%, blank otherwise
CALC	STENLAD	1= LAD stenosis > = 50%, blank otherwise
CALC	STENRCA	1= RCA stenosis > = 50%, blank otherwise
CALC	TIMEALOC	Time(days) from angiography to allocate
CALC	TIMEENRL	Time(days) from angiography to enrollment

NOTE: QV visit only for enrolled patients

Pgm.= cr7fqvnew.sas Doc.= qv7fcalc.wp

ACIP
FORM 7F PTCA ANGIOGRAPHY CORE LAB DATA
FM7FPTCA.SSD01

ITEM	VARIABLE NAME	CODES
	NEWID	Patient id
	VISIT	Visit type
		INTERVENTIONAL PROCEDURES Lesions 1-6
11A1- 11F1	LESSITEA- LESSITEF	Site codes (01-29) (See ACIP Coronary Artery Diagram) Site code 30= Other
11A2- 11F2	LESVEINA- LESVEINF	Vein graft 1= Yes, 2= No
11A3- 11F3	LESPROCA- LESPROCF	Procedures Code 1= Standard Balloon Angioplasty 2= Stent 3= Atherectomy 4= Laser 5= Laser Balloon 6= Other 8= Not available
11A4- llF4	LESAPPRA- LESAPPRF	Procedures Approach G= Graft, N= Native
11A5- 11F5	LESLOCA- LESLOCF	Location P= Proximal D= Distal M= Mid A= Distal Anastomasis 8= Not available
11A6- 11F6	LESSPREA- LESSPREF	% Stenosis pre
11A7- 11F7	LESGPREA- LESGPREF	Perfusion grade pre
11A8- llF8	LESSPSTA- LESSPSTF	% Stenosis post 998= Not available
11A9- 11F9	LESGPSTA- LESGPSTF	Post Perfusion grade Values= 0-3, 8= Not available
		POST PROCEDURAL, ANGIOGRAPHIC OBSERVATIONS Lesions l-6
12- 17	PP1SITE- PP6SITE	Site Code (See ACIP Coronary Artery Diagram)
12A1- 17A1	PP1DISS- PP6DISS	Dissection 1= Yes, 2= No

FORM 7F PTCA ANGIOGRAPHY CORE LAB DATA (Continued)

12A2-17A2	PP1TRAN-PP6TRAN	Transient occlusion 1= Yes, 2= No
12A3-17A3	PP1SUST-PP6SUST	Sustained occlusion 1= Yes, 2= No
12B1-17B1	PP1UND-PP6UND	Undefined lucencies 1= Yes, 2= No
12B2-17B2	PP1FLAP-PP6FLAP	Intimal flap 1= Yes, 2= No
12B3-17B3	PP1THRM-PP6THRM	Definite thrombus 1= Yes, 2= No
12C1-17C1	PP1OST-PP6OST	Ostial dissection 1= Yes, 2= No
12C2-17C2	PP1NOST-PP6NOST	Non-ostial dissection 1= Yes, 2 =No
12C3-17C3	PP1SIDE-PP6SIDE	Side-branch occlusion 1= Yes, 2= No
12C4-17C4	PP1NEW-PP6NEW	New side-branch stenosis 1= Yes, 2= No
12C5-17C5	PP1DIST-PP6DIST	Distal embolization 1= Yes, 2= No
18	COMPLETE	Complete revascularization Yes= 1, No= 2

ACIP
FORM 7F CALCULATED PTCA ANGIOGRAPHY CORE LAB DATA
PTCA7F.SSD01

SOURCE	VARIABLE NAME	CODES
	NEWID	Patient id
7F/11A3-11C3	LESPROCA-LESPROCC	Interventional procedure codes See FM7FPTCA.SSD01 Documentation
7F/11A-11C	LESSITEA-LESSITEC	Site Code (See ACIP Coronary Artery Diagram)
7F/11A6-llC6	LESSPREA-LESSPREC	% Stenosis Pre
7F/11A8-11C8	LESSPSTA-LESSPSTC	% Stenosis Post
Post procedural angiographic observations of lesions l-3		
7F/12-14	PP1SITE-PP3SITE	Site Code (See ACIP Coronary Artery Diagram)
		Codes 1= Yes, 2= No
7F/12A1-14A1	PP1DISS-PP3DISS	Dissection
7F/12A2-14A2	PP1TRAN-PP3TRAN	Transient occlusion
7F/12A3-14A3	PP1SUST-PP3SUST	Sustained occlusion
7F/12B1-14B1	PP1UND-PP3UND	Undefined lucencies
7F/12B2-14B2	PP1FLAP-PP3FLAP	Intimal flap
7F/12B3-14B3	PP1THRM-PP3THRM	Definite thrombus
7F/12C1-14C1	PP1OST-PP3OST	Ostial dissection
7F/12C2-14C2	PP1NOST-PP3NOST	Non-ostial dissection
7F/12C3-14C3	PP1SIDE-PP3SIDE	Side-branch occlusion
7F/12C4-14C4	PP1NEW-PP3NEW	New side-branch stenosis

FORM 7F CALCULATED PTCA ANGIOGRAPHY CORE LAB DATA
(Continued)

7F/12C5-14C5	PP1DIST-PP3DIST	Distal embolization
7F/18	COMPLETE	Complete revascularization 1= Yes, 2= No
		Complications in any lesion Codes 0=No, 1=Yes
CALC	DEFTHRM	Definite thrombus
CALC	DISSECT	Dissection
CALC	DISTAL	Distal embolization
CALC	INTIMAL	Intimal flap
CALC	NEWBRNCH	New side branch stenosis
CALC	NOSTIAL	Non ostial dissection
CALC	OSTIAL	Ostial dissection
CALC	SBRANCH	Side branch occlusion
CALC	SOCCLUDE	Sustained occlusion
CALC	TOCCLUDE	Transient occlusion
CALC	UNDEFINE	Undefined lucencies
CALC	INCLUDE	Was revascularization done? 0= Attempt, 1= PTCA
CALC	NSITE	Number of lesions attempted
CALC	RESULT	Anatomic success
		0 = No
		1 = Yes

NOTE: Includes only revascularization strategy for PTCA attempted or performed

Pgm.= cr7fptca.sas Doc.= ptca7fcalc.wp

ACIP
FORM 7F NCAD
ANGIOGRAPHY CORE LABORATORY DATA FOR PATIENTS WITH NORMAL CORONARIES
FM7FNCAD.SSD01

SAME FORMAT AS FILE FM7FANG.SSD01

Doc. fm7fncad.wp

ACIP
FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WITH NORMAL CORONARIES
NCAD7F.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
7F/2	VISDAYS	Days from enrollment to date of angiogram
		NATIVE SEGMENT ASSESSMENT
5A1- 5G1	ANGSITEA- ANGSITEG	Site code Codes= 01-29 (See ACIP Coronary Artery Diagram) Site code 30= Other
5A2- 5G2	ANGPERFA- ANGPERFG	Perfusion Grade Values= 0-3, 8= Not available
5A3- 5G3	ANGSTENA- ANGSTENG	% Stenosis
5A4- 5G4	ANGCOLLA- ANGCOLLG	Collateral 0= None, 1= Partial, 2= Complete, 8= Not available
5A5- 5G4	ANGCONTA- ANGCONTG	Stenosis Contour 0= Smooth lumen borders 1= Ill-defined borders 2= Irregular lumen borders 8= Not available
5A6- 5G6	ANGULCA- ANGULCG	Ulcer Grade 0= None, 1= Possible ulcer, 2= Definite ulcer, 8= Not available
5A7- 5G7	ANGTHRMA- ANGTHRMG	Thrombus Grade 0= None 1= Possible 2= <= 1/2 linear dimension vessel diameter 3= >1/2 but c 2 vessel diameters in size 4= >= 2 vessel diameter in size 8= Not available
5A8 5G8	ANGECCA- ANGECCG	Eccentric or Concentric Values= E or C 8= Not available

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WITH NORMAL CORONARIES (continued)

19B	EJFR	Global ejection fraction 9.98= Not available
		Codes for Items 19C1 - C5 and 19D6 - D10 1= Normal, 2= Hypokinetic, 3= Dyskinetic, 4= Akinetic, 5= Not assessed
19C1	ANTBASAL	Anterobasal
19C2	ANTLATER	Anterolateral
19C3	APICAL	Apical
19C4	DIAPHRAG	Diaphragmatic
19C5	POSBASAL	Posterobasal
19D6	BASSEPT	Basal septal
19D7	APISEPT	Apical septal
19D8	POSLATER	Posterolateral
19D9	INFLATER	Inferior lateral
19D10	SUPLATER	Superior lateral
CALC	AVESTEN	Average stenosis
CALC	MAXSTEN	Worst stenosis
CALC	NCOMPLAQ	Number of lesions with definite complex plague
CALC	NG1ULCER	Number of lesions grade 1 ulcer
CALC	NG2ULCER	Number of lesions grade 2 ulcer
CALC	NGRADE1	Number of lesions grade 1+ thrombus, ulcer, contour
CALC	NOCCOL	Number of lesions totally occluded, grade 1,2 collateral
CALC	NOCNOCOL	Number of lesions totally occluded, grade 0 collateral
CALC	NOVES	Number of vessels >= 50% stenosis Values = 1 - 3
CALC	NPERFLE2	Number of lesions, perfusion grade 0 - 2
CALC	NS100T0	Number of lesions stenosis = 100%, perfusion grade = 0

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WITH NORMAL CORONARIES (continued)

CALC	NS95TLE2	Number of lesions stenosis >= 95%, perfusion grade le 2
CALC	NS95_G12	Number of lesions stenosis >= 95%, perfusion grade 1 or 2
CALC	NS99TLE1	Number of lesions stenosis >= 99%, perfusion grade le 1
CALC	NSITE	Number of lesions measured
CALC	NSTEN50	Number of lesions, > = 50% stenosis
CALC	NSTEN95	Number of lesions, > = 95% c 100% stenosis
CALC	NTHRMGE2	Number of lesions grade 2+ thrombus
CALC	NTOTOCC	Number of totally occluded lesions
CALC	PROXGE50	1= > = 50% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PROXGE70	1= > = 70% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PRXLAD50	1= > = 50% stenosis, prox LAD, 0 otherwise
CALC	PRXLAD70	1= > = 70% stenosis, prox LAD, 0 otherwise
CALC	STENCX	1= CX stenosis > = 50%, blank otherwise
CALC	STENLAD	1= LAD stenosis > = 50%, blank otherwise
CALC	STENRCA	1= RCA stenosis > = 50%, blank otherwise

ACIP
FORM 7F INEL
ANGIOGRAPBY CORE LABORATORY DATA FOR PATIENTS
WHO ARE AECG INELIGIBLE
INEL7F.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
7F/2	VISDAYS	Days from enrollment to date of angiogram
		NATIVE SEGMENT ASSESSMENT
5A1- 5G1	ANGSITEA- ANGSITEG	Site code Codes= 01-29 (See ACIP Coronary Artery Diagram) Site code 30= Other
5A2- 5G2	ANGPERFA- ANGPERFG	Perfusion Grade Values= 0-3, 8= Not available
5A3- 5G3	ANGSTENA- ANGSTENG	% Stenosis
5A4- 5G4	ANGCOLLA- ANGCOLLG	Collateral 0= None, 1= Partial, 2= Complete, 8= Not available
5A5- 5G4	ANGCONTA- ANGCONTG	Stenosis Contour 0= Smooth lumen borders 1= Ill-defined borders 2= Irregular lumen borders 8= Not available
5A6- 5G6	ANGULCA- ANGULCG	Ulcer Grade 0= None, 1= Possible ulcer, 2= Definite ulcer, 8= Not available
5A7- 5G7	ANGTHRMA- ANGTBRMG	Thrombus Grade 0= None 1= Possible 2= <= 1/2 linear dimension vessel diameter 3= >1/2 but < 2 vessel diameters in size 4= >= 2 vessel diameter in size 8= Not available
5A8 5G8	ANGECCA- ANGECCG	Eccentric or Concentric Values= E or C 8= Not available

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WHO ARE AECG INELIGIBLE (continued)

19B	EJFR	Global ejection fraction 9.98= Not available
		Codes for Items 19C1 - C5 and 19D6 - D10 1= Normal, 2= Hypokinetic, 3= Dyskinetic, 4= Akinetic, 5= Not assessed
19C1	ANTBASAL	Anterobasal
19C2	ANTLATER	Anterolateral
19C3	APICAL	Apical
19C4	DIAPHRAG	Diaphragmatic
19C5	POSBASAL	Posterobasal
19D6	BASSEPT	Basal septal
19D7	APISEPT	Apical septal
19D8	POSLATER	Posterolateral
19D9	INFLATER	Inferior lateral
19D10	SUPLATER	Superior lateral
CALC	AVESTEN	Average stenosis
CALC	MAXSTEN	Worst stenosis
CALC	NCOMPLAQ	Number of lesions with definite complex plaque
CALC	NG1ULCER	Number of lesions grade 1 ulcer
CALC	NG2ULCER	Number of lesions grade 2 ulcer
CALC	NGRADE1	Number of lesions grade 1+ thrombus, ulcer, contour
CALC	NOCCOL	Number of lesions totally occluded, grade 1,2 collateral
CALC	NOCNOCOL	Number of lesions totally occluded, grade 0 collateral
CALC	NOVES	Number of vessels >= 50% stenosis Values = 1 - 3
CALC	NPERFLE2	Number of lesions, perfusion grade 0 - 2
CALC	NS100T0	Number of lesions stenosis = 100%, perfusion grade = 0

FORM 7F CALCULATED ANGIOGRAPBY CORE LAB DATA
FOR PATIENTS WHO ARE AECG INELIGIBLE (continued)

CALC	NS95TLE2	Number of lesions stenosis >= 95%, perfusion grade le 2
CALC	NS95_G12	Number of lesions stenosis >= 95%, perfusion grade 1 or 2
CALC	NS99TLE1	Number of lesions stenosis >= 99%, perfusion grade le 1
CALC	NSITE	Number of lesions measured
CALC	NSTEN50	Number of lesions, > = 50% stenosis
CALC	NSTEN95	Number of lesions, > = 95% < 100% stenosis
CALC	NTHRMGE2	Number of lesions grade 2+ thrombus
CALC	NTOTOCC	Number of totally occluded lesions
CALC	PROXGE50	1= > = 50% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PROXGE70	1= > = 70% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PRXLAD50	1= > = 50% stenosis, prox LAD, 0 otherwise
CALC	PRXLAD70	1= > = 70% stenosis, prox LAD, 0 otherwise
CALC	STENCX	1= CX stenosis > = 50%, blank otherwise
CALC	STENLAD	1= LAD stenosis > = 50%, blank otherwise
CALC	STENRCA	1= RCA stenosis > = 50%, blank otherwise

ACIP
FORM 7F THAL
ANGIOGRAPHY CORE LABORATORY DATA FOR PATIENTS
WITH THALIUM STUDIES
FM7FTHAL.SSD01

SAME FORMAT AS FILE FM7FANG.SSD01

Doc. fm7fthal.wp

ACIP
FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WITH THALIUM STUDIES
THAL7F.SSD01

SOURCE	VARIABLE NAME	CODE
	NEWID	Patient id
7F/2	VISDAYS	Days from enrollment to date of angiogram
		NATIVE SEGMENT ASSESSMENT
5A1- 5G1	ANGSITEA- ANGSITEG	Site code Codes= 01-29 (See ACIP Coronary Artery Diagram) Site code 30= Other
5A2- 5G2	ANGPERFA- ANGPERFG	Perfusion Grade Values= 0-3, 8= Not available
5A3- 5G3	ANGSTENA- ANGSTENG	% Stenosis
5A4- 5G4	ANGCOLLA- ANGCOLLG	Collateral 0= None, 1= Partial, 2= Complete, 8= Not available
5A5- 5G4	ANGCONTA- ANGCONTG	Stenosis Contour 0= Smooth lumen borders 1= Ill-defined borders 2= Irregular lumen borders 8= Not available
5A6- 5G6	ANGULCA- ANGULCG	Ulcer Grade 0= None, 1= Possible ulcer, 2= Definite ulcer, 8= Not available
5A7- 5G7	ANGTHRMA- ANGTHRMG	Thrombus Grade 0= None 1= Possible 2= <= 1/2 linear dimension vessel diameter 3= >1/2 but c 2 vessel diameters in size 4= >= 2 vessel diameter in size 8= Not available
5A8 5G8	ANGECCA- ANGECCG	Eccentric or Concentric Values= E or C 8= Not available

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WITH THALIUM STUDIES (continued)

19B	EJFR	Global ejection fraction 9.98= Not available
		Codes for Items 19C1 - C5 and 19D6 - D10 1= Normal, 2= Hypokinetic, 3= Dyskinetic, 4= Akinetic, 5= Not assessed
19C1	ANTBASAL	Anterobasal
19C2	ANTLATER	Anterolateral
19C3	APICAL	Apical
19C4	DIAPHRAG	Diaphragmatic
19C5	POSBASAL	Posterobasal
19D6	BASSEPT	Basal septal
19D7	APISEPT	Apical septal
19D8	POSLATER	Posterolateral
19D9	INFLATER	Inferior lateral
19D10	SUPLATER	Superior lateral
CALC	AVESTEN	Average stenosis
CALC	MAXSTEN	Worst stenosis
CALC	NCOMPLAQ	Number of lesions with definite complex plague
CALC	NG1ULCER	Number of lesions grade 1 ulcer
CALC	NG2ULCER	Number of lesions grade 2 ulcer
CALC	NGRADE1	Number of lesions grade 1+ thrombus, ulcer, contour
CALC	NOCCOL	Number of lesions totally occluded, grade 1,2 collateral
CALC	NOCNOCOL	Number of lesions totally occluded, grade 0 collateral
CALC	NOVES	Number of vessels >= 50% stenosis Values = l - 3
CALC	NPERFLE2	Number of lesions, perfusion grade 0 - 2
CALC	NS100T0	Number of lesions stenosis = 100%, perfusion grade = 0

FORM 7F CALCULATED ANGIOGRAPHY CORE LAB DATA
FOR PATIENTS WITH THALIUM STTJDIES (continued)

CALC	NS95TLE2	Number of lesions stenosis >= 95%, perfusion grade le 2
CALC	NS95_G12	Number of lesions stenosis >= 95%, perfusion grade 1 or 2
CALC	NS99TLE1	Number of lesions stenosis >= 99%, perfusion grade le 1
CALC	NSITE	Number of lesions measured
CALC	NSTEN50	Number of lesions, > = 50% stenosis
CALC	NSTEN95	Number of lesions, > = 95% < 100% stenosis
CALC	NTHRMGE2	Number of lesions grade 2+ thrombus
CALC	NTOTOCC	Number of totally occluded lesions
CALC	PROXGE50	1= > = 50% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PROXGE70	1= > = 70% stenosis, prox LAD, CX or RCA, 0 otherwise
CALC	PRXLAD50	1= > = 50% stenosis, prox LAD, 0 otherwise
CALC	PRXLAD70	1= > = 70% stenosis, prox LAD.0 otherwise
CALC	STENCX	1= CX stenosis > = 50%, blank otherwise
CALC	STENLAD	1= LAD stenosis > = 50%, blank otherwise
CALC	STENRCA	1= RCA stenosis > = 50%, blank otherwise