TIM1 II

DATA TAPE CODING MANUAL

JANUARY 1993

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General Introduction

The Thrombolysis in Myocardial Infarction TIM1 II was designed to compare the following two treatment strategies in patients with acute myocardial infarction: (1) routine coronary arteriography performed 18 to 48 hours after the administration of rt-PA, followed by prophylactic PTCA (or CABG) if arteriography demonstrated that the anatomy was suitable (this was termed the "invasive strategy") and (2) conventional care without coronary arteriography and PTCA during the six weeks after random assignment to treatment, unless there was evidence of recurrent spontaneous or exercise-induced ischemia (the "conservative strategy"). One substudy included in this trial examined the effects of early as compared with deferred administration of a relatively cardioselective beta-adrenergic blocking agent in eligible patients. Patients were treated with recombinant tissue plasminogen activator (rt-PA). Data are from analysis files as of January 1991. A summary of the design features follows:

TIMI II

Start Date: 4/11/86 Stop Date: 6/30/88
No. Treated: 3339
Design Features:
- rt-PA (G11044) 150 mg over 6 hrs (90 with initial 9 mg bolus, 20, 10, 10, 10, 10);
- On October 21, 1986 dose changed to rt-PA 100 mg over 6 hrs (60 with initial 6 mg bolus, 20, 5, 5, 5, 5);
- Onset of pain < 4 hrs;
- Randomized to PTCA at 18-48 hrs or a conservative strategy in which PTCA was used only if ischemia occurred spontaneously or at the time of pre-discharge exercise testing;
- Heparin 5000 U bolus and 1000 U/hr one hour after bolus; IV heparin for 5 days;
- Aspirin 80 mg qd;
- In IIB study patients were also randomized to immediate IV Beta-blocker or deferred oral Beta-blocker.

Description of Variables on the Data Tape

The first (short version) analysis file documentation contains a list of items by form (page vi to xiii). The second (long version) analysis file documentation contains the items, variable names and possible codes (Appendix B).

Copies of TIMI forms with annotations denoting the variable names are being submitted in a separate binder with this manual.

Data Tape Specification

The accompanying tape is g-track, -labeled, and written in EBCDIC with a density of ~~1600~~ 6250 bpi. Thus, although written on a Data General Computer, the tape is in IBM format.

Tape specifications: SAS datasets in transport format.

[redacted]

The datasets on the tape can be read under the AOS/VS, PRIMOS, or VMS operating system using the COPY procedure with the IMPORT option. The datasets can be read under a CMS, OS, or VSE operating system using the XCOPY procedure with the IMPORT option. The reserved libref IXTAPE must be used in the PROC COPY to refer to the transport library.

The tape contains seventeen SAS files corresponding to TIM1 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.

Special Considerations

a) The original identification number containing clinic and patient number has been replaced with a new sequence number, NEWID (l-3339).

b) Time is recorded in military time.

c) Days to event are calculated with reference to treatment initiation date. Time to events occurring on the same date as treatment initiation is defined as zero days.

Further Information on TIM1 II

For further information on the TIM1 II study, the user is directed to the following publications.

1. TIM1 Study Group. Comparison of invasive and conservative strategies after treatment with intravenous tissue plasminogen activator in acute myocardial infarction: Results of the Thrombolysis in Myocardial Infarction (TIMI) Phase II Trial. N Engl J Med 1989;320:618-27.

2. Bairn DS, Braunwald E, Feit F, Knatterud GL, Passamani ER, Robertson TL, Rogers WJ, Solomon RE, Williams Do. The Thrombolysis in Myocardial Infarction (TIMI) Trial Phase II: Additional information and perspectives. J Am Coll Cardiol 1990;15:1188-92.

3. Gore JM, Sloan M, Price TR, Randall AM, Bovill E, Collen D, Forman S, Knatterud G, Sopko G, Terrin ML. Intracerebral hemorrhage, cerebral infarction, and subdural hematoma following acute myocardial infarction and thrombolytic therapy in the Thrombolysis in Myocardial Infarction Study (TIM1 II Pilot and Clinical Trial). Circulation 1991;83:448-459.

4. Roberts R, Rogers W, Mueller HS, Lambrew CT, Diver DJ, Smith HC, Willerson JT, Knatterud GL, Forman S, Passamani E, Zaret BL, Wackers FJT, Braunwald E. Immediate versus deferred beta-blockade following myocardial infarction: Results of the Thrombolysis in Myocardial Infarction (TIMI) II-B Study. Circulation 1991;83:422-437.

5. Bovill EG, Terrin ML, Stump DC, Berke A, Frederick M, Collen D, Feit F, Gore J, Hillis LD, Lambrew C, Leiboff R, Mann KG, Markis JE, Pratt C, Sharkey S, Sopko G, Tracy R, Chesebro J for the TIM1 Investigators. Hemorrhagic events during treatment with intravenous recombinant tissue-type plasminogen activator, heparin and aspirin for acute myocardial infarction: Results of the Thrombolysis in Myocardial Infarction (TIMI) Phase II Trial. Am Intern Med 1991;115:256-265.

6. Bairn DS, Diver DJ, Feit F, Greenberg MA, Holmes DR, Weiner BH, Williams DO, Schweiger MJ, Brown BG, Frederick MM, Knatterud GL, Braunwald E for the TIM1 II Investigators. Coronary angioplasty performed within the Thrombolysis in Myocardial Infarction (TIM1 II) Study. Circulation 1992;85:93-105.

7. Zaret BL, Wackers FJT, Terrin ML, Ross R, Weiss M, Slater J, Morrison J, Bourge RC, Passamani E, Knatterud G, Braunwald E for the TIM1 Investigators. Assessment of global and regional left ventricular performance at rest and during exercise following thrombolytic therapy for acute myocardial infarction: Results of the Thrombolysis in Myocardial Infarction (TIM1 II) Study. Am J Cardiol 1992;69:1-9.

8. Williams DO, Braunwald E, Knatterud G, Babb J, Bresnahan J, Greenberg MA, Raizner A, Wasserman A, Robertson T, Ross R and the TIMI Investigators. One-Year results of the Thrombolysis in Myocardial Infarction Investigation (TIMI) Phase II Trial. Circulation 1992;85:533-542.

9. Mueller HS, Cohen LS, Braunwald E, Forman S, Feit F, Ross A, Schweiger M, Cabin H, Davison R, Miller D, Solomon R, Knatterud GL, for the TIM1 Investigators. Analyses of patient subgroups in the Thrombolysis in Myocardial Infarction (TIMI) Trial, Phase II: Predictors of early morbidity and mortality. Circulation 1992;85:1254-1264.

10. Kleiman NS, Terrin M, Mueller H, Chaitman B, Roberts R, Knatterud GL, Solomon R, McMahon RP, Braunwald E and the TIM1 Investigators. Mechanisms of early death despite thrombolytic therapy: Experience from the Thrombolysis in Myocardial Infarction Phase II (TIM1 II) Study. JACC 1992;19:1129-35.

TIMI II ANALYSIS FILES

ARRANGEMENT OF FILES BY FORM

FORM	SAS FILE NAME	NUMBER OF RECORDS	NUMBER OF VARIABLES
03	NIH.II03.SSD	3339	73
04	NIH.II04.SSD	3339	94
05	NIH.II05.SSD	3339	123
06, 7C, 7F	NIH.IICATH.SSD	3339	266
08A, 08C, 08D, 39	NIH.II08.SSD	3339	23
10	NIH.II10.SSD	3339	144
11, 12, 13	NIH.IIFU.SSD	3339	55
14, 23	NIH.II14.SSD	3339	108
15, 16, 17, 23, 25, 43	NIH.II17.SSD	3339	67
19	NIH.II19.SSD	3339	100
24, 26, 44	NIH.II44.SSD	3339	65
27, 28	NIH.II2728.SSD	52	90
40, 41	NIH.II40.SSD	3339	39
CORE LAB DATA			
CONTRAST VENTRICULOGRAM	NIH.IILV.SSD	3339	68
QUALIFYING ECG	NIH.IIECG.SSD	3339	42
COAGULATION	NIH.IIGT.SSD	3339	22
OTHER DATA			
RECURRENT PAINFUL ISCHEMIC EVENTS	NIH.IIRPIE.SSD	3339	9

TIMI II Analysis File Documentation
Item List

Form 03 Rev 1, 2, 3, 4, 5, Screening Form

Item 3 - date and time of qualifying ECG
Item 5 - sex
Item 7 - age
Item 9A - date and time of pain onset (if missing use Form 5D Item 2)
Item 10A - leads with ST elevation
Item 10B - ST elevation in inferior leads
Item 10C - ST elevation in anterior leads
Item 10D - ST elevation in I and AVL leads
Item 11 - presence of Q-waves
Item 11A - leads with Q-waves
Item 12 - ST depression $\geq$ 0.1 mv
Item 12A - leads with ST depression
Items 15A-15G, 16 - beta-blocker exclusion criteria
Items 17-22 - risk factors
Item 31 - location of qualifying ECG (Rev 5 only)

Form 04 Rev 0, Admission Form

Item 3 - race
Item 4 - education
Items 5, 5A-5E - smoking habits
Item 6 - activity at pain onset
Items 7, 7A, 8, 9, 9B - previous pain episodes
Items 10, 10B1-10B5 - history of MI
Items 11A-11D - previous events
Items 12A-12J - previous diseases or conditions
Items 15A-15P - previous medications
Item 16 - baseline height
Item 17 - baseline weight
Item 18 - baseline heart rate
Item 19 - baseline respiratory rate
Item 20 - baseline blood pressure
Item 21 - baseline neck vein distension
Items 22A-22D, 22D1A-22D1E - heart sounds
Items 23A, 23B - integument
Items 25-38 - baseline blood chemistries (if #31, 32, or 35 is missing, appropriate item on Form 19 is used)

Form 05 Rev 0. Treatment Assignment Form

Item 5 - treatment assignment
Items 6, 7A, 7B - initiation of rt-PA
Items 8, 9A, 9C - initiation of metoprolol
Item 10 - date and time of heparin bolus
Item 11 - date and time of rt-PA initiation
Item 12, 13 - date and time of IV and oral beta blockers
Item 14 - date and time of heparin infusion initiation
Item 16 - transfusions within 24 hours
Item 17, 18A-18M - complications within first 24 hours
Item 20 - hemodynamic measurements
Items 21A-21H - timing of events during rt-PA infusion
Items 22, 23A-23H - arrhythmias within 24 hours
Items 24A, 24C, 24D, 24E - assessment of chest pain

Form 06 Rev 0. 1 PTCA Procedures Form (maximum of 2 forms, one protocol and one nonprotocol)

Rev 0 Item	Rev 1 Item
2	2 - date and time of PTCA
3	3 - PTCA type
4	4 - emergency or elective PTCA (only for nonprotocol PTCA)
5	5 - indication for PTCA (only for nonprotocol PTCA)
6,7	6,7 - PTCA attempts
8A-8V	8A-8W - procedure notes for PTCA on lesion 1
9A-9G	9A-9H - PTCA complications
10	10 - total elapsed fluoroscopy time
12	12 - 24 hour complications
14A-14C	14A-14C - angina status prior to PTCA (only for nonprotocol PTCA)

Form 7C Rev 0. Cardiac Catheterization Procedures Form (maximum of 3 forms: protocol, nonprotocol and hospital discharge)

Item 2 - date and time of catheterization
Item 4 - protocol/nonprotocol catheterization
Item 5 - reason for nonprotocol catheterization
Items 6A-6D - left ventricular pressure
Items 8A, 8B - perfusion grade and stenosis
Item 9 - infarct artery
Item 12, 13A-13E, 14, 14A-14C - complications
Item 15 - arrhythmias
Item 16A-16D - clinical complications

Form 7F Rev 0, 1, 2, 3, 4 Coronary Arteriography Visual Asessment (maximum of 3 forms: protocol, nonprotocol and hospital discharge)

Rev 0,1 Item	Rev 2,3 Item	Rev 4 Item	
3 calc	4	4	- film type (P, NP, HD)
7	6	6	- dominance
5	7	7	- infarct artery
7.1-7.16	7.1-7.16	7.1-7.27	- stenosis inallsegments (sequence 1 filmonly)
7.1-7.16	7.1-7.16	7.1-7.27	- collaterals in all segments (sequence 1 film only)
6A	8D1	8D1	- pre stenosis, pre grade
8B	8D2	8D2	- post stenosis, post grade
calc	8F	8F	- success of procedure (recalculated based on grade and stenosis)

Form 8A Rev 0. Rest/Exercise RVG Shipping Form (hospital discharge and 6 weeks)

Item 2 - date of study
Item 4A - rest study done
Item 4B - exercise study done
Item 32 - peak exercise stage (if missing use Form 8D #17)
Item 33 - exercise ECG results (Clinic interpretation)
Item 34 - chest pain (used if Form 39 Item 11 is missing)

Form 8C Rev 0,1. Resting RVG Analysis Report (hospital discharge and 6 weeks)

Item 8A - resting global LVEF (left ventricular ejection fraction)

Form 8D Rev 0, 1. Exercise RVG Analysis Report (hospital discharge and 6 weeks)

Items 5A - baseline LVEF
Items 14A - recovery RVG results
Item 16 - LVEF change (recalculated using peak exercise and baseline EF)
Item 17 - peak exercise stage (only used if Form 8A Item 32 is missing)
Item 18 - peak exercise LVEF

Form 10 Rev 0. Hospital Discharge Form

Item 2 - Date of hospital discharge
Item 3 - patient dead or alive at hospital discharge
Items 5, 5A, 5B - confirmation of myocardial infarction
Item 7 - clinical complications occurred
Item 10 - date of congestive heart failure
Item 11 - date of cardiogenic shock
Item 12 - date of ventricular septal rupture
Item 13 - date of mitral regurgitation

Form 10 Rev 0. **Hospital Discharge** Form (Continued)

Item 14 - date of cardiac arrest
Item 15 - date of recurrent ischemic pain
Items 16, **16A-16L** - hemorrhagic complications with dates
Items 17, **17A-17B** - occurrence of infection with dates
Items 18, **18A-18F** - vascular complications with dates
Items 19, **19A-19F** - thoracic complications with dates
Items 20, **20A-20D** - other complications with dates
Items 21-30 - special procedures with dates
Items **40A1-40P2** - drugs prescribed during hospitalization and at hospital discharge
Items 41, 41A - heparin infusion
Items 42, 42B - oral beta blocker therapy

Form 11 Rev 0. **Follow-up** Visit Form (6 weeks and 1 year)

Item 2 - date of follow-up
Item 6 - activity level
Item 7 - current Canadian heart class
Item **9B** - cardiac arrest
Item **9C** - congestive heart failure
Item **9D** - angina pectoris
Items **13A**, B, Cl, **C5**, D-K, L-P - current medication

Form 12 Rev 0. Missed Visit Form (6 weeks and 1 year)

Item 2 - date of contact
Item 4 - able to locate patient
Item 4B - need Coordinating Center help
Item 5 - alive at contact
Item 7 - reason visit was missed
Item 8B - cardiac arrest
Item 8C - congestive heart failure
Item 8D - angina pectoris
Item **12A** - source of information for this form

Form 13 Rev 0. Telephone Contact Form (3 months, 6 months, 18 months, 2 years, 3 years, 4 years)

Item 2 - date of contact
Item 4 - able to locate patient
Item 4B - need Coordinating Center help

Form 14 Rev 0. Subseauent Hospitalization Form (up to 5 forms)

Item 2 - date of hospitalization
Item 7 - cause of hospitalization is cardiovascular
Items 8A-8G - description of cardiovascular reasons

Form 15 Rev 0. Death Notification Form

Item 3 - date of death (use only if missing on Form 17)
Item 5 - preliminary cause of death

Form 16 Rev 0. Cause of Death Form

Item 16 - autopsy

Form 17 Rev 2. 3. MMCC Death Classification Form

Item 2 - date and time of death (if missing use Form 15)
Items 6A-6E - complications
Items 7, 8A, 8B, 8B1 - death from cardiovascular disease (For Rev 2)
Items 7, 8A, SB, 8B1, 8B2 - death from cardiovascular disease (For Rev 3)
Items ac - fatal cardiac disease

Form 19 Rev 0. Laboratory Data Form

Item 3 - CK upper limit of normal
Items 3A-3S - date and time of CK measurements and total CK in (IU/L)
Item 4 - Hospital limits APTT
Items 5A-5C - hemoglobin, hematocrit, platelet count (used only if Form 04 items are missing)
Item 6A - first day heparin dose (U USP)
Item 6B - first day aspirin dose (mg)
Item 6C - first day coumadin dose (mg)
Item 6D - first day metoprolol dose (mg)
Item 6E - other beta-blockers given on first day
Items 7A, 7B, 7C, 7D, 7E - second day laboratory data
Items 8A, 8B, SC, 8D, 8E - third day laboratory data
Items 9A, 9B, 9C, 9D, 9E - fourth day laboratory data
Items 10A, 10B, 10C, 10D, 10E - fifth day laboratory data
Items 11A, 11B, 11C, 11D, 11E - sixth day laboratory data
Items 12A, 12B, 12C, 12D, 12E - seventh day laboratory data
Items 13A, 13B, 13C, 13D, 13E - eighth day laboratory data
Items 14A, 14B, 14C, 14D, 14E - ninth day laboratory data
Items 15A, 15B, 15C, 15D, 15E - tenth day laboratory data

Form 23 Rev 0. 1. 2. Myocardial Infarction Event Form (multiple events possible, current maximum = 3)

Item 2 - date and time of event (used only if Form 43 is missing)
Item 3B - reappearance of pain

Form 24 Rev 0. 1. Hemorrhagic Event Form (multiple events possible)

Item 2 - date and time of event (used only if Form 44 #2 is missing)
Item 13 - transfusion given to treat event
Items 14A, 14B - whole blood and packed cells transfused (used only if Form 26, #4 is missing)

Form 25 Rev 0. 1. Cardiac Surgery Form (multiple events possible)

Item 2 - date and time of surgery
Item 4 - emergency or elective
Item 4A - reason for surgery
Item 5A, B, C - angina status
Item 6, 6A, 6B1 - exercise test
Item 7 - angiography performed
Items 8A-8F - arteries grafted
Items 9A-D - conduits used
Items 10A, 10B - complications
Item 11 - transfusion (Rev 1 only)

Form 26 Rev 0. Transfusion Report Form

Item 2 - date of first transfusion
Items 3A-3D - reason for transfusion
Items 4A, 4B - number of units transfused (whole blood and packed cells) - (if missing, Form 24 is used)

Form 27 Rev 0. Severe Neuroloeic Event Form

Item 6 - alcohol consumption
Item 11 - date and time of onset
Item 12 - signs and symptoms
Item 13 - onset
Item 14 - maximum stable deficit
Item 15 - improvement within 24 hours
Item 16, 16A - blood pressure change
Item 17 - medication
Item 18 - cardiovascular stability
Item 19-21 - examination
Item 46 - CT scan
Item 53 - recovery

Form 28 Rev 0. Severe Neuroloaic Event Classification Form

Item 2 - date of event
Item 3A-E - classification
Item 4A-F, 5A-F - location
Item 6 - hours from onset to entry
Item 7 - class of infarct
Item 8 - class of hemorrhage
Item 9, 10 - extension of hemorrhage
Item 11A-N - casual factors

Form 39 Rev 0. Bicycle Ergonometry Test Form (hospital discharge and 6 weeks)

Item 11 - chest pain

Form 40 Rev 0. 1. One-Year Treadmill Exercise Test Form

Item 2 - date of study
Item 5 - primary reason for stopping
Item 7 - total treadmill time
Item 8 - final stage entered
Item 9 - % maximum heart rate achieved
Item 10A, 10B, 10C - heart rate and blood presure at rest, peak exercise and recovery
Items 11, 12 - chest pain
Items 13, 14 - fall in systolic blood pressure
Items 15A, 15B, 15C, 15D - resting ECG showed LBBB, RBBB, LVH or ST-segment elevation
Items 16, 17, 18, 19A, 19B, 20, 21 - description of ST depression
Items 22, 23 - description of ST-segment elevation
Items 27, 28 - ischemic response (calculated)

Form 41 Rev 0. 1. Treadmill Exercise Test Non-Performance Form

Item 3 - reason for not performing test

Form 43 Rev 1. 2. Nonfatal Myocardial Infarction Event Classification Form (multiple events)

Rev 1 Item	Rev 2 Item
2	2 - date and time of nonfatal MI
—	4 - timing of MI
4	SD, 6A - classification of event

Form 44 Rev 1. 2. Hemorrhagic Event Classification Form (multiple events)

Item 2 - date and time of hemorrhagic event
Item 4A - severity of event
Item 4B - surgical event
Item 5A - primary location
Item 5B - contributing location
Item 8A - event occurred within 24 hours of rt-PA initiation

File Qualifying ECG

- ECG number
- sequence number
- mean RR interval in msec
- PR interval in msec
- Q amplitude in leads I, II, III, AVR, AVL, AVF, V_1-V_6
- R amplitude in leads I, II, III, AVR, AVL, AVF, V_1-V_6
- ST deviation in leads I, II, III, AVR, AVL, AVF, V_1-V_6
  (positive value indicates ST elevation, a negative value indicates ST depression)

File GT. Coagulation Core Lab Data

- fibrinogen (Claus) at pre-treatment, 50 minutes, 5 hours and 8 hours
- FDP at pre-treatment, 50 minutes, 5 hours, and 8 hours
- TPA at pre-treatment, 50 minutes, 5 hours, and 8 hours
- Plasminogen at pre-treatment, 50 minutes, 5 hours, and 8 hours
- Alpha-2 antiplasmin at pre-treatment, 50 minutes, 5 hours, and 8 hours

File LV. Contrast Left Ventriculograms (protocol, hospital discharge andnonprotocol)

- systolic and diastolic volume
- stroke volume
- cardiac output
- ejection fraction
- hypokinesis
- hyperkinesis
- length of hypokinetic segment
- length of akinetic or dyskinetic segment

APPENDIX B

TIM1 II ANALYSIS FILES

ARRANGEMENT OF FILES AS OF 9/90

FORM 03 (REV 0, 1, 2, 3, 4, 5)
Screening Form

ITEM	LENGTH	NAME	CODES
	11	FORM03	1 = Form received
3	F10.5	ERTIME	Emergency-room time (days) to treatment initiation (negative)
5	11	SEX	1 = Male, 2 = Female
7	13	AGE	Years
9A	12	ONMO	Month of pain onset
		ONDA	Day of pain onset
		ONYR	Year of pain onset
		ONHR	Hour of pain onset (military)
		ONMN	Minute of pain onset
9A	F10.5	ONTIME	Onset of symptoms time (days) to treatment initiation (negative)
10A	12	NSTE	Total number of leads with ST elevation: 0-12
10A	11	STEII	1 = item checked 0 = item not checked
		STEIII	
		STEAVF	
		STEV1	
		STEV2	
		STEV3	
		STEV4	
		STEV5	
		STEV6	
		STEI	
		STEAVL_1	
		STEAVR	
10B	11	STEINF	1 = Yes, 2 = No
10C	11	STEANT	
10D	11	STEAVL	
11	11	QWAVES	1 = Yes, 2 = No
11A	12	NQ	Number of leads with Q waves: 0-12
11A	11	QII	1 = item checked 0 = item not checked
		QIII	
		QAVF	
		QV1	
		QV2	
		QV3	
		QV4	
		QV5	
		QV6	
		QI	
		QAVL	
		QAVR	

FORM 03 (REV 0, 1, 2, 3, 4, 5)
Screening Form
(Continued)

ITEM	LENGTH	NAME	CODES
12	I1	STD	1 -Yes, 2 = No
12A	12	NSTD	Number of leads with ST depression: 0-12
	I1	STDII	1 = ST depression present in lead 0 = not present
	I1	STDIII	
	I1	STDAVF	
	I1	STDV1	
	I1	STDV2	
	I1	STDV3	
	I1	STDV4	
	I1	STDV5	
	I1	STDV6	
	I1	STDI	
	11	STDAVL	
	I1	STDAVR	
15A	I1	BBINELA	1 = Yes, 2 = No
15B	I1	BBINELB	
15c	I1	BBINELC	
15D	I1	BBINELD	
15E	I1	BBINELE	
15F	I1	BBINELF	
15G	I1	BBINELG	
16	I1	BBINEL	1 = Yes, 2 = No
17	I1	BLMI	1 = Yes, 2 = No
18	I1	BLRALES	1 = Yes, 2 = No
18A	I1	BLEXTENT	0 = None 1 = ≤ 1/3 lung fields 2 = > 1/3 lung fields but not all 3 = both entire lung fields
19	I1	BLHYPO	1 = Yes, 2 -No
20	I1	BLAF	1 = Yes, 2 = No
21	I1	BLPE	1 = Yes, 2 = No
22	I1	BLSHOCK	1 -Yes, 2 -No
31	I1	WHEREECG	1 = TIM1 Clinical Center 2 = Emergency room extension (only available on Rev. 5)

FORM 03 (REV 0, 1, 2, 3, 4, 5)
Screening Form
(Continued)

ITEM	LENGTH	NAME	CODES
CALCULATED	11	HIGHRISK	1 = Yes 0 = No (Defined as any of the following being present: Age ≥ 70, prior MI, anterior MI, rales > 1/3 lung fields, hypotension, atria1 fibrillation or flutter, pulmonary edema or cardiogenic shock)
CALCULATED	I1	TWOHRS	1 = Treatment was initiated within 2 hours (≤ 2) of pain onset 0 = Treatment initiated later than 2 hours after pain onset

FORM 04 (REV 0)
Admission Form

ITEM	LENGTH	NAME	CODES
	11	FORM04	1 = Form received
3	11	RACE	1 = White, 2 = Black, 3 = Hispanic, 4 = Other
4	11	EDUCATE	1 = No formal education 2 = ≤ Grade 11 3 = High school graduate 4 = Some college 5 - 4 yr degree 6== Some graduate school 7 = Graduate degree
5	I1	SMOKE	1 = Yes, 2 = No
5A	11	MAXPACKS	0 = None 1 = ≤ 1/2 pack 2 = 1/2 < packs ≤ 1 3 - 1 < packs ≤ 2 4 - > 2 packs
5B	I2	YRSMOKE	number of years smoked (0 = None)
5c	11	CURSMOKE	1 -Yes, 2 = No
5D	11	PACKSDAY	0 = None 1 = ≤ 1/2 pack 2 = 1/2 < packs ≤ 1 3 = 1 < packs ≤ 2 4 = > 2 packs
5E	I1	STOPSMOK	o = Never stopped 1 = ≤ 3 months 2 = 3 < months ≤ 12 3 = 1 < years ≤ 5 4 = > 5 years 5 = Never smoked
6	I1	ACTONSET	1 = sleeping 2 = rest 3 - mild physical activity 4 - moderate physical activity 5 = marked physical activity
7	11	INDXPAIN	1 -Yes, 2 = No
7A	I1	OTHEPISD	minimum of 7A1-7A6: 0 = None 1 = < 1 hour 2 = 1-2 hours 3 = 3-5 hours 4 = 6-11 hours 5 = 12-23 hours 6 = 24-48 hours

FORM 04 (REV 0)
Admission Form
(Continued)

ITEM	LENGTH	NAME	CODES
8A	I1	BLPATTA	0 - No, 1 = Yes
8B	11	BLPATTB	
8C	I1	BLPATTC	
8D	I1	BLPATTD	
8E	I1	BLPATTE	
8F	I1	BLPATTF	
8G	I1	BLPATTG	
CALCULATED	I1	PATT3WK	0 = None 1 = No pattern 2 = New onset (D) 3 = Increasing frequency (E and no D) 4 - Variant (F only) or (F and G only)
CALCULATED	I1	ANG3WK	0 - None (A) 1 - Unstable (B) or (G only) 2 - Stable (C, D, E and not B) 3 = Variant (F and G only) or (F only)
9	I1	CHSTPAIN	1 -Yes, 2 -No
9A	I1	BLANGINA	0 = Probably not angina or not angina 1 - Definite angina or probable angina
9B	I1	ANGONSET	0 - None 1 = ≤ 7 days 2 - 8-14 days 3 = 15-21 days 4 = 22-30 days 5 - 31-180 days 6 - 6 months-l year 7 = > 1 year
10	I1	F04BLMI	1 = Definite, 2 - No, 3 - Suspect, 4 = Unknown
10B1	I1	BLMILOC1	0 -No, 1 = Yes
10B2	I1	BLMILOC2	
10B3	I1	BLMILOC3	
10B4	I1	BLMILOC4	
10B5	I1	BLMILOC5	
11A	I1	BLCHF	1 - Definite, 2 - No, 3 - Suspect, 4 - Unknown
11B	I1	BLICIA	
11C	I1	BLSTK	
11D	I1	BLIC	
12A	I1	BLDIAB	1 = Yes, 2 = No, 3 - Unknown
12B	I1	BLHYP	
12c	I1	BLPVD	
12D	I1	BLVHD	
12E	I1	BLOCD	
12F	I1	BLGI	
12G	I1	BLHMD	
12H	I1	BLRENAL	
121	I1	BLNEURO	
12J	I1	BLOTHDIS	

FORM 04 (REV 0)
Admission Form
(Continued)

ITEM	LENGTH	NAME	CODES
15A	11	BLRXA	0 = No 1 = < 6 hrs. 2 = 6-24 hrs. 3 = > 24 hrs.
15B	11	BLRXB	
15C1	11	BLRXC1	
15C2	11	BLRXC2	
15D	11	BLRXD	
15E	11	BLRXE	
15F	11	BLRXF	
15G	11	BLRXG	
15H	11	BLRXH	
151	11	BLRXI	
15J	11	BLRXJ	
15K	11	BLRXK	
15L	11	BLRXL	
15M	11	BLRXM	
15N	11	BLRXN	
150	11	BLRXO	
15P	11	BLRXP	
16	13	BLHT	Height in cm
17	F5.1	BLWT	Weight in kg
18	13	BLHR	Heart rate in beats/minute
19	12	BLRESP	Respiratory rate in respirations/minute
20A	13	BLSBP	Systolic blood pressure (mm Hg)
20B	13	BLDBP	Diastolic blood pressure (mm Hg)
21	11	BLNKVEIN	1 = Present, 2 = Absent, 3 = Unknown
22A	11	BLS3	1 = Present, 2 = Absent, 3 = Unknown
22B	11	BLS4	
22c	11	BLPFR	
22D	11	BLMURMUR	
22D1	11	BLBSE	0 = No, 1 = Yes
22D1B	11	BLMR	
22D1C	11	BLAR	
22DlD	11	BLVSR	
22D1E	11	BLOTHMUR	
23A	11	BLECCHY	1 = Present, 2 = Absent
23B	11	BLHEMAT	1 = Present, 2 = Absent
25	F4.1	BLCREAT	mg/dl
26	13	BLBUN	mg/dl
27	F4.1	BLBILI	mg/dl
28	14	BLSGOT	IU/L

FORM 04 (REV 0)
Admission Form
(Continued)

ITEM	LENGTH	NAME	CODES
29	14	BLLDH	IU/L
30	13	BLALKPHS	IU/L
31	F4.1	BLHCT	% (if missing, Form 19 Item 5B was used)
32	F4.1	BLHGB	gm/dl (if missing, Form 19 Item 5A was used)
33	F4.1	BLWBC	thousands/mm^3
34	F3.1	BLK	mEq/L
35	I4	BLPLAT	thousands/mm^3 (if missing, Form 19 Item 5C was used)
36	11	BLUPROT	1 = Present, 2 = Absent, 3 = Unknown
37	11	BLOCCBLD	1 = Present, 2 = Absent, 3 = Unknown
38	11	BLGUIAIC	1 = Present, 2 = Absent, 3 = Unknown

FORM 05 (REV 0)
Treatment Assignment Form

ITEM	LENGTH	NAME	CODES
	11	FORM05	1 = Form received
HEADER	11	PHASE	1 = Open Label E 2 = Phase II
5	11	ASSIGN	1 = 2 hr PTCA 2 = 18-24 hr PTCA } PTCA Timing Study 3 = No PTCA 4 = IV BB/18-48 hr PTCA 5 = IV BB/No PTCA 6 = DEF BB/18-48 hr PTCA } Beta-Blocker Study 7 = DEF BB/No PTCA 8 = BB Inel./18-48 hr PTCA 9 = BB Inel./No PTCA
CALCULATED	11	DOSEASGN	1 = 150 mg rt-PA 2 = 100 mg rt-PA
CALCULATED	11	PTCAGRP	1 = Immediate invasive 2 = Delayed invasive 3 = Conservative
CALCULATED	11	BBGRP	1 = Immediate Beta-Blocker 2 = Deferred Beta-Blocker
6	11	TRTINIT	1 = Yes, 2 = No
7A	13	RTPADOSE	mg
7B	12	RTPALESS	1 = Urticaria 2 = Fever or chills 3 = Nausea or vomiting 4 = Bleeding at arterial access 5 = Bleeding at central vein access 6 = Bleeding at other puncture sites 7 = Other bleeding 8 = Convulsions 9 = Anaphylaxis 10 = Hypotension 11 = Bronchospasm 12 = Death 13 = Other
8	11	IVMET	1 = Yes, 2 -No
9A	12	IVDOSE	mg
9C	13	ORALDOSE	mg
10	11	HEPBOL	0 = No, 1 = Yes
	F10.5	HEPBTIME	Time from treatment initiation (days)
11	512	TIMO, TIDA, TIYR, TIHR, TIMN	Date and time of rt-PA initiation (ALL TIME VARIABLES ARE CALCULATED FROM THIS ONE)

FORM 05 (REV 0)
Treatment Assignment Form
(Continued)

ITEM	LENGTH	NAME	CODES
12	11	IVBB	0 = No, 1 = Yes
	F10.5	IVBBTIME	Time from treatment initiation (days)
13	11	ORALBB05	0 = No, 1 = Yes
	F10.5	ORBBTIME	Time from treatment initiation (days)
14	11	HEPINF	0 = No, 1 = Yes
	F10.5	HEPITIME	Time from treatment initiation (days)
16	I1	TF24	1 = Yes, 2 = No
17	11	COMP	1 = Yes, 2 = No
18A	11	COMPA	1 = Did not occur 2 = Occurred, but did not interrupt rt-PA treatment 3 = Interrupted rt-PA treatment
18B	11	COMPB	
18C	I1	COMPC	
18D	I1	COMPD	
18E	11	COMPE	
18F	11	COMPF	
18G	11	COMPG	
18H	I1	COMPH	
181	11	COMPI	
18J	11	COMPJ	
18K	11	COMPK	
18L	11	COMPL	
18M	I1	COMPM	
20	13	HR0	Beats per minute
	13	HR30	
	13	HR60	
	13	HR90	
	13	HR120	
	13	HR150	
	13	HR180	
	13	SBP0	mm Hg
	13	SBP30	
	I3	SBP60	
	13	SBP90	
	13	SBP120	
	13	SBP150	
	13	SBP180	
	13	DBP0	mm Hg
	13	DBP30	
	13	DBP60	
	13	DBP90	
	IT	DBP120	
	13	DBP150	
	13	DBP180	

FORM 05 (REV 0)
Treatment Assignment Form
(Continued)

ITEM	LENGTH	NAME	CODES
21A	11, 13	RPEVA, RPEVAMIN	1 -Yes, 2 -No If Yes, minutes from treatment initiation
21B	11, 13	RPEVB, RPEVBMIN	
21c	11, 13	RPEVC, RPEVCMIN	
21D	11, 13	RPEVD, RPEVDMIN	
21E	11, 13	RPEVE, RPEVEMIN	
21F	11, 13	RPEVF, RPEVFMIN	
21G	11, 13	RPEVG, RPEVGMIN	
21H	11, 13	RPEVH, RPEVHMIN	
22	I1	ARR24	1 = Yes, 2 = No
23A1	I1	ARRA1	1 = None 0 = Arrhythmias appeared
23B1	I1	ARRB1	
23C1	I1	ARRC1	
23D1	I1	ARRD1	
23E1	I1	ARRE1	
23F1	I1	ARRF1	
23G1	I1	ARRG1	
23H1	I1	ARRH1	
23A2	I1	ARRA2	1 = Prior to thrombolytic therapy 0 = None prior
23B2	I1	ARRB2	
23C2	I1	ARRc2	
23D2	I1	ARRD2	
2332	I1	ARRE2	
23F2	I1	ARRF2	
23G2	I1	ARRG2	
23H2	I1	ARRH2	
23A3	I1	ARRA3	1 = During thrombolytic therapy 0 = None during
23B3	I1	ARRB3	
23C3	I1	ARRc3	
23D3	I1	ARRD3	
2333	I1	ARRE3	
23F3	I1	ARRF3	
23G3	I1	ARRG3	
23H3	I1	ARRH3	
23A4	13	ARRA4	Minutes after onset of thrombolytic therapy (missing if none during therapy)
23B4	13	ARRB4	
2364	13	ARRc4	
23D4	13	ARRD4	
2334	13	ARRE4	
23F4	13	ARRF4	
23G4	13	ARRG4	
23H4	13	ARRH4	
23A5	I1	ARRA5	1 = After completion of thrombolytic therapy 0 = None after
23B5	I1	ARRB5	
23C5	I1	ARRc5	
23D5	I1	ARRD5	
2335	I1	ARRE5	
23F5	I1	ARRF5	
2365	I1	ARRG5	
23H5	11	ARRH5	

FORM 05 (REV 0)
Treatment Assignment Form
(Continued)

ITEM	LENGTH	NAME	CODES
24A	I1	PAINPRE	1 = Yes, 2 = No
24C	11	PAININIT	1 = Yes, 2 = No
24D	11	PAINCONC	1 = Yes, 2 -No
24E	11	PAINCOMP	1 = Increased 2 = Decreased but still present 3 = Same 4 = None

FORM 6 (REV 0)
PTCA Procedures Form

Data from the Protocol and first Nonprotocol PTCA
(Protocol variables suffixed by "P," Nonprotocol by "NP.")

ITEM	LENGTH	NAME	CODES
	11	F06P/F06NP	1 = Form received, 0 = not received
2	F10.5	F6TIMEP/F6TIMENP	Time to PTCA (days)
2	13	PTCADAYS	Integer days to first PTCA } on FORM17.SSD
2	F10.5	PPROTDAY	Days to Protocol PTCA
	F10.5	PNP1DAY	Days to first NP PTCA
	F10.5	PNP2DAY	Days to second NP PTCA
	F10.5	PNP3DAY	Days to third NP PTCA
4	11	PTCAEENP	1 = Emergency 2 = Elective
5	11	REASONNP	1 = Ischemia post infarction 2 = Re-infarction post infarction 3 = Other
6	11	SITE1P/SITE1NP	1 = Yes, 2 = No
7	11	SITE2P/SITE2NP	1 = Yes, 2 = No
8A1	11	L18AP/L18ANP	1 = Yes, 2 = No
8B1	12	L18BP/L18BNP	1 = Prox RCA 2 = Mid RCA 3 = Dist RCA 4 - RPDA 5 - RPLS 6 = 1st RPL 7 = 2nd RPL 8 = 3rd RPL 9 = Inf. septal 10 - AC marg 11 - LMCA 12 = Prox LAD 13 - Mid LAD 14 - Dist LAD 15 = 1st diag 16 - 2nd diag 17 - 1st septal 18 = Prox CX 19 = Dist CX 20 = 1st Ob marg 21 - 2nd Ob marg 22 - 3rd Ob marg 23 - LAV 24 - 1st LPL 25 - 2nd LPL 26 = 3rd LPL 27 = LPDA

FORM 6 (REV 0)
PTCA Procedures Form
(Continued)

ITEM	LENGTH	NAME	CODES
8C1	11	L18CP/L18CNP	
8D1	I1	L18DP/L18DNP	1 -Yes, 2 -No
8E1	I1	L18EP/L18ENP	
8F1	I1	L18FP/L18FNP	
8G1	I1	L18GP/L18GNP	Perfusion grade pre PTCA = 0, 1, 2, 3
8H1	I1	L18HP/L18HNP	
811	I1	L18IP/L18INP	
8J1	I1	L18JP/L18JNP	1 -Yes, 2 -No
8K1	I1	L18KP/L18KNP	
8L1	I1	L18LP/L18LNP	Perfusion grade post-PTCA = 0, 1, 2, 3
8M1	13	L18MP/L18MNP	% stenosis pre-PTCA (0 - 100)
8N1	13	L18NP/L18NNP	% stenosis post-PTCA (0 - 100)
801	13	L18OP/L18ONP	Gradient pre-PTCA (mm Hg)
8P1	13	L18PP/L18PNP	Gradient post-PTCA (mm Hg)
8Q1	12	L18QP/L18QNP	Outcome code 1 = ≥ 20% absolute reduction in stenosis - sustained 2 = ≥ 20% absolute reduction in stenosis - with transient reocclusion 3 = ≥ 20% absolute reduction in stenosis - followed by sustained reocclusion 4 = Failure to enter vessel 5 = Failure to reach lesion 6 = Failure to cross lesion 7 = Vessel resists dilation 8 = Equipment failure 9 = Other
8R1	I1	L18RP/L18RNP	Measure code 1 = Visual estimate 2 = Electronic calipers 3 = Manual caliper
CALCULATED	11	L18SP/L18SNP	1 = full 2 = partial 3 = none
8S1	13	L18TP/L18TNP	Seconds
ST1	11	L18UP/L18UNP	Number of catheters
8U1	F3.1	L1MMP/L1MMNP	mm
8V	12	L1INP/L1INNP	Number of inflations
8VA	13	L1SCP/L1SCNP	Seconds
8VB	13	LlATP/LlATNP	Atmospheres
9A	I1	COMPAP/COMPANP	
9B	11	COMPBP/COMPBNP	
9C	11	COMPCP/COMPCNP	
9D	11	COMPDP/COMPDNP	1 = Yes, 2 = No
9E	I1	COMPFP/COMPFNP	
9F	11	COMPGP/COMPGNP	
9G	I1	COMPHP/COMPHNP	
10	12	FTIMEP/FTIMENP	Minutes

FORM 6 (REV 0)
PTCA Procedures Form
(Continued)

ITEM	LENGTH	NAME	CODES
12A	I1	DEATHP/DEATHNP	1 = Yes, 2 = No
12B	I1	MIP/MINP	1 -Yes, 2 = No
12c	I1	SURGP/SURGNP	1 -Yes, 2 = No
14A	I1	ANGINANP	1 = definite angina 2 = probable angina 3 = probably not angina 4 = no angina
14B	I1	CHCNP	0 = 0 1 - I 2 = II 3 = III 4 = IV
14c	I1	EPISODNP	1 = Yes, 2 = No
CALCULATED	11	PTCASTAT	1 = ≤ 15 hours 2 = Protocol PTCA (declared protocol) 3 = Excluding Protocol, PTCA within 15 hours-14 days 4 = No procedure in 14 days
CALCULATED	I1	NPREASON	Reason for Non-Protocol PTCA (defined by Drs. Diver and Bairn) 0 = Emergency PTCA in first 15 hours 1 = Angina 2 = Re-infarction 3 = Positive ETT 4 = Physician request 5 = Clinical determination 6 = Delay due to unavailability of OR backup or clinical instability 7 = To facilitate non-cardiac surgery 8 = Error in treatment assignment

FORM 6 (REV 1)
PTCA Procedures Form

Data from the Protocol and first Nonprotocol PTCA
(Protocol variables suffixed by "P," Nonprotocol by "NP.")

ITEM	LENGTH	NAME	CODES
	I1	F06P/F06NP	1 = Form received, 0 = not received
2	F10.5	F6TIMEP/F6TIMENP	Time to PTCA (days)
2	13	PTCADAYS	Integer days to first PTCA
2	F10.5	PPROTDAY	Days to Protocol PTCA
	F10.5	PNP1DAY	Days to first NP PTCA
	F10.5	PNP2DAY	Days to second NP PTCA
	F10.5	PNP3DAY	Days to third NP PTCA
			} on FORM17.SSD
4	I1	PTCAEENP	1 = Emergency 2 = Elective
5	I1	REASONNP	1 = Ischemia post infarction 2 = Re-infarction post infarction 3 = Other
6	11	SITE1P/SITE1NP	1 -Yes, 2 = No
7	11	SITE2P/SITE2NP	1 -Yes, 2 = No
8A1	I1	L18AP/L18ANP	1 -Yes, 2 -No
8B1	12	L18BP/L18BNP	1 = Prox RCA 2 = Mid RCA 3 = Dist RCA 4 = RPDA 5 = RPLS 6 = 1st RPL 7- 2nd RPL 8- 3rd RPL 9 = Inf. septal 10 = AC marg 11 = LMCA 12 = Prox LAD 13 = Mid LAD 14 = Dist LAD 15 = 1st diag 16 = 2nd diag 17 = 1st septal 18 = Prox CX 19 = Dist CX 20 = 1st Ob marg 21 = 2nd Ob marg 22 = 3rd Ob marg 23 = LAV 24 = 1st LPL 25 = 2nd LPL 26 = 3rd LPL 27 = LPDA

FORM 6 (REV 1)
PTCA Procedures Form
(Continued)

ITEM	LENGTH	NAME	CODES
8C1	11	L18CP/L18CNP	1 = Yes, 2 -No
8D1	11	L18DP/L18DNP	
8E1	I1	L18EP/L18ENP	
8F1	I1	L18FP/L18FNP	
8G1	I1	L18GP/L18GNP	Perfusion grade pre-PTCA = 0, 1, 2, 3
8H1	I1	L18HP/L18HNP	1 -Yes, 2 -No
811	I1	L18IP/L18INP	
8J1	I1	L18JP/L18JNP	
8K1	I1	L18KP/L18KNP	
8L1	I1	L18LP/L18LNP	Perfusion grade post-PTCA = 0, 1, 2, 3
8M1	I3	L18MP/L18MNP	% stenosis pre-PTCA (0 - 100)
8N1	I3	L18NP/L18NNP	% stenosis post-PTCA (0 - 100)
801	I3	L18OP/L18ONP	Gradient pre-PTCA (mm Hg)
8P1	I3	L18PP/L18PNP	Gradient post-PTCA (mm Hg)
8Q1	I2	L18QP/L18QNP	Outcome code 1 = < 60% initial residual stenosis - sustained 2 = < 60% initial residual stenosis - with transient reocclusion 3 = < 60% initial residual stenosis - followed by sustained reocclusion 4 = Failure to enter vessel 5 = Failure to reach lesion 6 = Failure to cross lesion 7 = Vessel resists dilation 8 = Equipment failure 9 = Other
8R1	I1	L18RP/L18RNP	Measure code 1 = Visual estimate 2 = Electronic calipers 3 = Manual caliper
8S1	I1	L18SP/L18SNP	1 = full 2 = partial 3 = none
8T1	I3	L18TP/L18TNP	Seconds
SU1	I1	L18UP/L18UNP	Number of catheters
8V1	F3.1	L1MMP/L1MMNP	mm
8W1	I2	L1INP/L1INNP	Number of inflations
8WA1	I3	L1SCP/L1SCNP	Seconds
8WB1	I3	LlATP/LlATNP	Atmospheres
9A	I1	COMPAP/COMPANP	1 = Yes, 2 = No
9B	I1	COMPBP/COMPBNP	
9C	I1	COMPCP/COMPCNP	
9D	I1	COMPDP/COMPDNP	
9E	I1	COMPEP/COMPENP	
9F	I1	COMPFP/COMPFNP	
9G	I1	COMPGP/COMPGNP	
9H	I1	COMPHP/COMPHNP	
10	I2	FTIMEP/FTIMENP	Minutes

FORM 6 (REV 1)
PTCA Procedures Form
(Continued)

ITEM	LENGTH	NAME	CODES
12A	11	DEATHP/DEATHNP	1 = Yes, 2 = No
12B	11	MIP/MINP	1 = Yes, 2 = No
12c	11	SURGP/SURGNP	1 = Yes, 2 = No
14A	I1	ANGINANP	1 = definite angina 2 = probable angina 3 = probably not angina 4 = no angina
14B	I1	CHCNP	0 = 0 1 = I 2 = II 3 = III 4 = IV
14c	I1	EPISODNP	1 = Yes, 2 = No
CALCULATED	I1	PTCASTAT	1 = Early (< 15 hours) 2 = Protocol PTCA (declared protocol) 3 = Excluding Protocol procedures, PTCA within 15 hours-14 days 4 = No procedure in 14 days
CALCULATED	I1	NPREASON	Reason for Non-Protocol PTCA (defined by Drs. Diver and Bairn) 0 = Emergency PTCA in first 15 hours 1 = Angina 2 = Reinfarction 3 = Positive ETT 4 = Physician request 5 = Clinical deterioration 6 = Delay due to unavailability of OR backup or clinical instability 7 = To faciliate non-cardiac surgery 8 = Error in treatment assignment

FORM 7C (REV 0)
Cardiac Catheterization Procedures Form (Clinic)

There is a set of variables for the protocol/hospital discharge/ first nonprotocol catheterizations.

ITEM	LENGTH	NAME	CODES
2	F10.5	CATHTIME/CTIMEHD/CTIMENP	Time (days) to catheterization
2	12	CATHDAYS	Integer days to first catheterization (on FORM17.SSD)
2	F10.5	CPDAY	Days to Protocol cath } on FORM17.SSD
	F10.5	CHDDAY	Days to HD cath
	F10.5	CNP1DAY	Days to first NP cath
	F10.5	CNP2DAY	Days to second NP cath
	F10.5	CNP3DAY	Days to third NP cath
4	11	F7C/F7CHD/F7CNP	1 = form received, 0 = none
5	I1	REAS7C	1 = Ischemia post infarction 2 = Re-infarction 3 = Other
6A	13	LVPSBPP/LVPSBPHD/LVPSBPNP	mm Hg
6B	13	LVEDBPP/LVEDBPHD/LVEDBPNP	mm Hg
6C	13	ASBP/ASBPHD/ASBPNP	mm Hg
6D	13	ADBP/ADBPHD/ADBPNP	mm Hg
12	11	F7CCOMP/F7CHDC/F7CNPC	1 -Yes. 2 = No
13A	I1	F7CCOMPA/F7CHDCA/F7CNPCA	1 = Yes, 2 = No
13B	I1	F7CCOMPB/F7CHDCB/F7CNPCB	
13C	11	F7CCOMPC/F7CHDCC/F7CNPCC	
13D	11	F7CCOMPD/F7CHDCD/F7CNPCD	
13E	11	F7CCOMPE/F7CHDCE/F7CNPCE	
14	11	F7COCC/F7CHDOC/F7CNPOC	1 = Yes, 2 = No
14A	I1	F7COCCA/F7CHDOCA/F7CNPOCA	
14B	11	F7COCCB/F7CHDOCB/F7CNPOCB	
14c	11	F7COCCC/F7CHDOCC/F7CNPOCC	
15	11	F7CARR/F7CHDARR/F7CNPARR	1 = Yes, 2 = No
16A	I1	F7CPE/F7CHDPE/F7CNPPE	1 = Yes, 2 = No
16B	11	F7CHPO/F7CHDPO/F7CNPPO	
16C	I1	F7CCA/F7CHDCA/F7CNPCA	
16D	11	F7CANA/F7CHDANA/F7CNPANA	

FORM 7C (REV 0)
Cardiac Catheterization Procedures Form (Clinic)

Three sets of variables corresponding to the first three catheterizations.

ITEM	LENGTH	NAME	CODES
2	F10.5	CTIME1/CTIME2/CTIME3	Days to catheterization
4	I1	F7C1/F7C2/F7C3	1 = Protocol, 2 = HD, 3 = Non-Protocol
6A	13	LVPSBP1/LVPSBP2/LVPSBP3	mm Hg
6B	13	LVEDBP1/LVEDBP2/LVEDBP3	mm Hg
6C	13	ASBP1/ASBP2/ASBP3	mm Hg
6D	13	ADBP1/ADBP2/ADBP3	mm Hg
8A	I1	F7CGR1/F7CGR2/F7CGR3	Grade = 0, 1, 2 or 3
8B	I1	F7CST1/F7CST2/F7CST3	% stenosis 0-100
9	I1	F7CIRA1/F7CIRA2/F7CIRA3	Clinic assessment of IRA 1 = LAD 2 = Diagonal 3 = Circumflex 4 = Obtuse marginal 5 = RCA/RPDA 6 = LMCA
12	I1	F7CCOMP1/F7CCOMP2/F7CCOMP3	1 = Yes, 2 = No
13A	I1	F7CCMPA1/F7CCMPA2/F7CCMPA3	1 = Yes, 2 = No
13B	I1	F7CCMPB1/F7CCMPB2/F7CCMPB3	
13c	I1	F7CCMPC1/F7CCMPC2/F7CCMPC3	
13D	11	F7CCMPD1/F7CCMPD2/F7CCMPD3	
13E	11	F7CCMPE1/F7CCMPE2/F7CCMPE3	
14	11	F7COCC1/F7COCC2/F7COCC3	1 = Yes, 2 = No
14A	11	F7COCCA1/F7COCCA2/F7COCCA3	
14B	11	F7COCCB1/F7COCCB2/F7COCCB3	
14c	I1	F7COCCC1/F7COCCC2/F7COCCC3	
15	I1	F7CARR1/F7CARR2/F7CARR3	1 = Yes, 2 = No
16A	11	F7CPE1/F7CPE2/F7CPE3	1 -Yes, 2 = No
16B	11	F7CHPO1/F7CHPO2/F7CHPO3	
16C	11	F7CCA1/F7CCA2/F7CCA3	
16D	11	F7CANA1/F7CANA2/F7CANA3	

FORM 7F (REV 0, 1, 2, 3, 4, 6)
Coronary Arteriography Visual Assessment (Core Lab)

There is a set of variables for the protocol/hospital discharge/ first nonprotocol catheterizations.

ITEM	LENGTH	NAME	CODES
Rev 0, 1 header Rev 2, 3, 4, # 4	11	F7F/F7FHD/F7FNP	1 = form received, 0 = none
Rev 0, 1 # 7 Rev 2, 3, 4, # 6	I1	DOMNANCE*	1 = balance 2 = right 3 = left
Rev 0, 1 # 5 Rev 2, 3, 4, # 7 Rev 6, #6	12	ARTERY*	Rev 0, 1, 2, 3 / Rev 4, 6 1 = Prox RCA / 1 2 = Mid RCA / 2 3 = Dist RCA / 3 4 = RPDA / 4 5 = RPLS / 5,6,7,8,9,10 6 = LMCA / 11 7 = Prox LAD / 12 8 = Mid LAD / 13 9 = Dist LAD / 14 10 = 1st DIAG / 15 11 = 2nd DIAG / 16,17 12 = Prox CX / 18 13 = Dist CX / 19 14 = OMB 1 / 20 15 = OMB 2 / 21,22 16 = LAV / 23,24,25,26,27 18 = Anterior infarct / 29 19 = Inferior. (or other infarct) / 30
CALCULATED	I1	VESSEL*	1 = RCA (if missing, Form 7C item 9 was used) 2 = LMCA 3 = LAD 4 = cx
CALCULATED	I1	NOVES*	Number of vessels with ≥ 60% stenosis
CALCULATED	13	STENRCA*	% stenosis Rev 0, 1, 2, 3: Maximum of #7-1 to #7-5 Rev 4: Maximum of #7-1 To #7-10 Rev 6: Maximum of #6-1 To #6-10
CALCULATED	13	STENLMCA*	% stenosis Rev 0, 1, 2, 3: #7-6 Rev 4: #7-11 Rev 6: #6-11

*Only available for the first film analyzed by the Core Lab.

FORM 7F (REV 0, 1, 2, 3, 4, 6)
Coronary Arteriography Visual Assessment (Core Lab)

There is a set of variables for the protocol/hospital discharge/ first nonprotocol catheterizations.
(Continued)

ITEM	LENGTH	NAME	CODES
CALCULATED	13	STENLAD*	% stenosis Rev 0, 1, 2, 3: Maximum of #7-7 to #7-11 Rev 4: Maximum of #7-12 to #7-17 Rev 6: Maximum of #6-12 to #6-17
CALCULATED	13	STENCX*	% stenosis Rev 0, 1, 2, 3: Maximum of #7-12 to #7-16 Rev 4: Maximum of #7-18 to #7-27 Rev 6: Maximum of #6-18 to #6-27
REVISIONS 0, 1			
#6A	11	PREGR/GRADEHD/GRADENP	o-3 } If missing, Form 7C #8 was used
	13	PREST/STENHD/STENNP	%
#6B	11	POSTGR	o-3
	13	POSTST	%
REVISIONS 2, 3, 4			
#8D1	11	PREGR/GRADEHD/GRADENP	o-3 } If missing, Form 7C #8 was used
	13	PREST/STENHD/STENNP	%
#8D2	I1	POSTGR	o-3
	13	POSTST	%
REVISION 6			
#7A1	I1	PREGR/GRADEHD/GRADENP	O - 3 } If missing, Form 7C #8 was used
	13	PREST/STENHD/STENNP	%
#7A2	I1	POSTGR	o-3
	13	POSTST	%
CALCULATED	11	SUCCESS*	1 = full success 2 = partial success 3 = not successful
CALCULATED	I1	COLLAT*	0 = None, 1 = collaterals to IRA present

*Only available for the first film analyzed by the Core Lab.

FORM 7F (REV 0, 1, 2, 3, 4, 6)
Coronary Arteriography Visual Assessment (Core Lab)

There is a set of variables for the first three catheterizations.

ITEM	LENGTH	NAME	CODES
Rev 0, 1 header Rev 2, 3, 4 #4	11	F7F1/F7F2/F7F3	1 = Protocol 2 = HD 3 = Non-Protocol
Revisions 0, 1			
#6A	11	F7FPREG1/F7FPREG2/F7FPREG30-3	
	13	F7FPRES1/F7FPRES2/F7FPRES3%	
#6B	11	F7FPSTG1/F7FPSTG2/F7FPSTG30-3	
	13	F7FPSTS1/F7FPSTS2/F7FPSTS3%	
Revisions 2, 3, 4			
#8D1	11	F7FPREG1/F7FPREG2/F7FPREG30-3	
	13	F7FPRES1/F7FPRES2/F7FPRES3%	
#8D2	11	F7FPSTG1/F7FPSTG2/F7FPSTG30-3	
	13	F7FPSTS1/F7FPSTS2/F7FPSTS3%	
Revision 6			
#7A1	11	F7FPREG1/F7FPREG2/F7FPREG30-3	
	13	F7FPRES1/F7FPRES2/F7FPRES3%	
#7A2	11	F7FPSTG1/F7FPSTG2/F7FPSTG30-3	
	13	F7FPSTS1/F7FPSTS2/F7FPSTS3%	

FORM 8A (REV 0)
Radionuclide Shipping Record - REST/EXERCISE RVG (Clinic)

Data collected at Hospital Discharge (HD) and 6 weeks post study entry (6W)

ITEM	LENGTH	NAME	CODES
2	13	F8ADAYHD, F8ADAY6W	Days from treatment initiation
4A	11	RESTHD, REST6W	1 = Done, 2 = Not done
4B	11	EXERHD, EXER6W	1 = Done, 2 = Not done
17E-18E*	13	RSTSBPHD, RSTSBP6W	Mean resting systolic blood pressure (mm Hg)
19E-26E*	13	EXSBPHD, EXSBP6W	SBP at peak stage during exercise (mm Hg)
27E*	13	RECSBPHD, RECSBP6W	Recovery systolic blood pressure (mm Hg)
17F-18F*	13	RSTHRHD, RSTHR6W	Mean resting heart rate (beats/minute)
19F-26F*	13	EXHRHD, EXHR6W	Exercise heart rate at peak stage (beats/minute)
27F	13	RECHRHD, RECHR6W	Recovery heart rate (beats/minute)
32**	11	STAGEHD, STAGE6W	Stage = 1, 2, ... 8
33	11	MUGAHD, MUGA6W	1 = Positive 2 = Negative 3 = Indeterminate
34*	11	EXPAINHD, EXPAIN6W	1 -Yes, 2 = No

*Used only if corresponding items on Form 39 are missing.

**Used only if corresponding items on Form 08D are missing.

FORM 8C (REV 0, 1)
Radionuclide Data Analysis Report - Resting RVG (Core Lab)

Data collected at Hospital Discharge (HD) and 6 weeks (6W) post study entry

ITEM	LENGTH	NAME	CODES
8A	12	RESTEFHD, RESTEF6W	%
8B	F5.2	PFRHD, PFR6W	v/sec (not available on Rev 0)
9A1	I1	ANAHD, ANA6W	0 = No 1 = Yes
9B1	I1	ANBHD, ANB6W	
9C1	I1	ANCHD, ANC6W	
9D1	I1	ANDHD, AND6W	
9E1	I1	ANEHD, ANE6W	
9F1	I1	ANFHD, ANF6W	
9G1	I1	ANGHD, ANG6W	
9H1	I1	ANHHD, ANH6W	
911	I1	ANIHD, ANI6W	
9J1	I1	ANJHD, ANJ6W	
9K1	11	ANKHD, ANK6W	
11	I1	RVMIHD, RVMI6W	1 = Yes, 2 = No
11A	I1	RVMIHDA, RVMI6WA	1 = Diffuse, 2 = Local
12A1	F4.1	SDBSEPHD, SDBSEP6W	Mean S.D.
12A2	F4.1	SDASEPHD, SDASEP6W	
12A7	F4.1	SDIFAHD, SDIFA6W	
12A10	F4.1	SDIFLHD, SDIFL6W	
12A11	F4.1	SDPTLHD, SDPTL6W	
12A1	12	RBSEPHD, RBSEP6W	%
12A2	12	RASEPHD, RASEP6W	
12A7	12	RIFAHD, RIFA6W	
12A10	12	RIFLHD, RIFL6W	
12A11	12	RPTLHD, RPTL6W	
12B4	F4.1	SDABHD, SDAB6W	Mean S.D.
12B5	F4.1	SDANTHD, SDANT6W	
12B6	F4.1	SDAPHD, SDAP6W	
12B8	F4.1	SDINFHD, SDINF6W	
12B9	F4.1	SDPBHD, SDPB6W	
13A1	F3.1	LADPOHD, LADPO6W	Mean S.D.
13A3	F3.1	LADPERHD, LADPER6W	
13B1	F3.1	RCAPOHD, RCAPO6W	
13B3	F3.1	RCAPERHD, RCAPER6W	
14A1	13	P01HD, P016W	Number chords (o-100)
14A2	12	P01ANTHD, P01ANT6W	Number of anterior chords (0-60)
14A3	12	P01INFHD, P01INF6W	Number of inferior chords (0-40)
14B1	13	P02HD, P026W	Number of chords (o-100)
14B2	I2	P02ANTHD, P02ANT6W	Number of anterior chords (0-60)
14B3	12	P02INFHD, P02INF6W	Number of inferior chords (0-40)

FORM 8C (REV 0, 1)
Radionuclide Data Analysis Report - Resting RVG (Core Lab)
(Continued)

ITEM	LENGTH	NAME	CODES
15A1	13	PR1HD, PR16W	Number of chords (o-100)
15A2	12	PR1ANTHD, PR1ANT6W	Number of anterior chords (O-60)
15A3	12	PR1INFHD, PR1INF6W	Number of inferior chords (O-40)
15B1	13	PR2HD, PR26W	Number of chords (o-100)
15B2	12	PR2ANTHD, PR2ANT6W	Number of anterior chords (O-60)
15B3	12	PR1INFHD, PR1INF6W	Number of inferior chords (O-40)

FORM 8D (REV 0, 1)
Radionuclide Data Analysis Report - Exercise RVG (Core Lab)

Data collected at Hospital Discharge (HD) and 6 weeks (6W) post study entry

ITEM	LENGTH	NAME	CODES
5A	12	BASEEFHD, BASEEF6W	%
5D	13	BASEBSHD, BASEBS6W	%
5E	13	BASEASHD, BASEAS6W	
5F	13	BASEIAHD, BASEIA6W	
5G	13	BASEILHD, BASEIL6W	
5H	13	BASEPLHD, BASEPL6W	
PEAR STAGE C	14	PEAKCHHD, PEAKCH6W	%
D	13	PEAKBSHD, PEAKBS6W	
E	13	PEAKASHD, PEAKAS6W	
F	13	PEAKIAHD, PEAKIA6W	
G	13	PEAKILHD, PEAKIL6W	
H	13	PEAKPLHD, PEAKPL6W	
14A	13	RECEFHD, RECEF6W	
14c	14	RECCHHD, RECCH6W	
14D	13	RECBSHD, RECBS6W	
14E	13	RECASHD, RECAS6W	%
14F	13	RECIAHD, RECIA6W	
14G	13	RECILHD, RECIL6W	
14H	13	RECPLHD, RECPL6W	t
15A	13	BESTHD, BEST6W	%
15B	13	WORSTHD, WORST6W	%
16	I1	EFCHGHD, EFCHG6W	1 = fall ≥ 5% 2 = increase ≥ 5% 3 = no change
17	I1	STAGEHD, STAGE6W	Peak stage (l-8)
18	12	EXEFHD, EXEF6W	%
19	I1	PSPESVHD, PSPESV6W	1 = Fall 2 = Increase 3 = No change
CALCULATED	11	RESULTHD,RESULT6W	1 = Test done, result was negative (good outcome) 2 = Test done, but not negative and not positive 3 = Test done, result was positive 4 = Test not done, but patient was alive 5 = Test not done, patient had died

FORM 10 (REV 0)
Hospital Discharge Form

ITEM	LENGTH	NAME	CODES
	11	FORM10	1 = Form received
2	13	HDDAY	Days from treatment initiation to hospital discharge
3	I1	HDSTAT	1 - Alive, 2 - Dead
5	I1	MICONFIR	1 -Yes, 2 = No
5A	11	MICK	1 - Yes, 2 - No, 3 - Not done
5B	11	MIECG	1 - Yes, 2 = No, 3 - Not done
7	11	CLNCOMHD	1 -Yes, 2 = No
10	11	CHF	1 -Yes, 2 = No
10	13	HDCHFT	Days from treatment initiation to congestive heart failure
11	11	SHOCK	1 = Yes, 2 = No
11	13	HDSHKT	Days from treatment initiation to cardiogenic shock
12	11	VSRUP	1 -Yes, 2 = No
12	13	HDVSRUPT	Days from treatment initiation to ventricular septal rupture
13	11	MITRAL	1 = Yes, 2 -No
13	13	HDMITT	Days from treatment initiation to mitral regurgitation
14	I1	ARREST	1 = Yes, 2 = No
14	13	HDARSTT	Days from treatment initiation to cardiac arrest
15	11	PAIN	1 -Yes, 2 -No
15	13	HDPNT	Days from treatment initiation to recurrent ischemic pain
16	11	HEMCOM	1 -Yes, 2 = No
16A	11	HEMCOMA	1 -Yes, 2 -No
16A	13	HDHEMAT	Days from treatment initiation to hematoma
16B	11	HEMCOMB	1 -Yes, 2 -No
16B	I3	HDHEMBT	Days from treatment initiation to bleeding at puncture site
16C	11	HEMCOMC	1 = Yes, 2 = No
16C	I3	HDHEMCT	Days from treatment initiation to GI bleeding
16D	11	HEMCOMD	1 -Yes, 2 = No
16D	13	HDHEMDT	Days from treatment initiation to significant decrease in hematocrit or hemoglobin
16E	11	HEMCOME	1 = Yes, 2 -No
16E	13	HDHEMET	Days fro-m treatment initiation to transfusion

FORM 10 (REV 0)
Hospital Discharge Form
(Continued)

ITEM	LENGTH	NAME	CODES
16F	11	HEMCOMF	1 = Yes, 2 = No
16F	13	HDHEMFT	Days from treatment initiation to bleeding requiring surgery
16G	I1	HEMCOMG	1 = Yes, 2 = No
16G	13	HDHEMGT	Days from treatment initiation to retroperitoneal bleeding
16H	11	HEMCOMH	1 = Yes, 2 = No
16H	13	HDHEMHT	Days from treatment initiation to intracranial bleeding
161	I1	HEMCOMI	1 = Yes, 2 = No
161	13	HDHEMIT	Days from treatment initiation to fatal hemorrhage
16J	I1	HEMCOMJ	1 = Yes, 2 = No
16J	13	HDHEMJT	Days from treatment initiation to thrombocytopenia
16K	I1	HEMCOMK	1 = Yes, 2 = No
16K	I3	HDHEMKT	Days from treatment initiation to hematuria
16L	11	HEMCOML	1 = Yes, 2 = No
16L	13	HDHEMLT	Days from treatment initiation to other bleeding
17	11	INFCOM	1 -Yes, 2 = No
17A	11	INFCOMA	1 = Yes, 2 = No
17A	13	HDINFAT	Days from treatment initiation to infection at puncture site
17B	I1	INFCOMB	1 = Yes, 2 -No
17B	13	HDINFBT	Days from treatment initiation to infection at other site
18	11	VASCOM	1 -Yes, 2 = No
18A	11	VASCOMA	1 -Yes, 2 = No
18A	13	HDVASAT	Days from treatment initiation to arterial embolism
18B	I1	VASCOMB	1 = Yes, 2 = No
18B	13	HDVASBT	Days from treatment initiation to arterial thrombosis
18C	11	VASCOMC	1 = Yes, 2 = No
18C	13	HDVASCT	Days from treatment initiation to venous thrombophlebitis
18D	11	VASCOMD	1 -Yes, 2 = No
18D	13	HDVASDT	Days from treatment initiation to cerebrovascular accident

FORM 10 (REV 0)
Hospital Discharge Form
(Continued)

ITEM	LENGTH	NAME	CODES
18E	I1	VASCOME	1 = Yes, 2 = No
18E	13	HDVASET	Days from treatment initiation to arterial dissection
18F	I1	VASCOMF	1 = Yes, 2 = No
18F	13	HDVASFT	Days from treatment initiation to other vascular complication
19	I1	THRCOM	1 -Yes, 2 -No
19A	I1	THRCOMA	1 = Yes, 2 = No
19A	13	HDTHRAT	Days from treatment initiation to pleuritis/ pleural effusion
19B	I1	THRCOMB	1 -Yes, 2 = No
19B	13	HDTHRBT	Days from treatment initiation to pericarditis/ pericardial effusion
19C	I1	THRCOMC	1 -Yes, 2 = No
19C	13	HDTHRCT	Days from treatment initiation to hemothorax
19D	I1	THRCOMD	1 = Yes, 2 = No
19D	13	HDTHRDT	Days from treatment initiation to hemomediastinum
19E	11	THRCOME	1 = Yes, 2 = No
19E	13	HDTHRET	Days from treatment initiation to pulmonary embolism
19F	I1	THRCOMF	1 -Yes, 2 = No
19F	13	HDTHRFT	Days from treatment initiation to other thoracic complication
20	I1	OTHCOM	1 = Yes, 2 -No
20A	I1	OTHCOMA	1 = Yes, 2 = No
20A	13	HDOTHAT	Days from treatment initiation to allergic reaction
20B	I1	OTHCOMB	1 = Yes, 2 = No
20B	13	HDOTHBT	Days from treatment initiation to renal insufficiency
2oc	I1	OTHCOMC	1 = Yes, 2 = No
2oc	13	HDOTHCT	Days from treatment initiation to liver function abnormalities
20D	I1	OTHCOMD	1 -Yes, 2 = No
20D	13	HDOTHDT	Days from treatment initiation to other complication
21	I1	SURPRO	1 -Yes, 2 = No

FORM 10 (REV 0)
Hospital Discharge Form
(Continued)

ITEM	LENGTH	NAME	CODES
22	11	ECARD	1 = Yes, 2 -No
22	13	HDCRDT	Days from treatment initiation to electrical cardioversion/defibrillation
23	I1	RTCATH	1 = Yes, 2 = No
23	13	HDRCTHT	Days from treatment initiation to right heart catheterization
24	I1	CARDCATH	1 = Yes, 2 -No
24	13	HDCCTHT	Days from treatment initiation to left heart cardiac catheterization
25	I1	IABP	1 = Yes, 2 = No
25	13	HDIABT	Days from treatment initiation to intra-aortic balloon counter pulsation
26	I1	CARSUR	1 -Yes, 2 = No
26A	I1	CABG	1 = Yes, 2 = No
26A	13	HDCABGT	Days from treatment initiation to CABG
26B	I1	OTHSUR	1 = Yes, 2 = No
26B	13	HDOSURT	Days from treatment initiation to other surgery
28	I1	EPACE	1 = Yes, 2 = No
28	13	HDPACET	Days from treatment initiation to electrical pacing
28A	I1	EPACETYP	0 = None, 1 = Temporary, 2 = Permanent,
29	I1	EPHYS	1 = Yes, 2 = No
29	13	HDEPHST	Days from treatment initiation to electro-physiology studies
30	I1	OTHSP	1 = Yes, 2 = No
30	13	HDOSPT	Days from treatment initiation to other special procedures

FORM 10 (REV 0)
Hospital Discharge Form
(Continued)

ITEM	LENGTH	NAME	CODES
40A1	11	HDRXA	
40A2	11	HDDRXA	
40B1	11	HDRXB	
40B2	11	HDDRXB	
40C11	11	HDRXC1	
40C12	11	HDDRXC1	
40C21	11	HDRXC2	
40C22	il	HDDRXC2	
40D1	11	HDRXD	
40D2	11	HDDRXD	
40E1	11	HDRXE	
40E2	11	HDDRXE	
40F1	11	HDRXF	
40F2	11	HDDRXF	
40G1	11	HDRXG	
40G2	11	HDDRXG	
40H1	11	HDRXH	1 = Yes, 2 = No
40H2	11	HDDRXH	In-hospital variables prefixed by "HD."
4011	11	HDRXI	Hospital discharge variables prefixed by "HDD"
4012	11	HDDRXI	(missing HDDRXA-HDDRKP if patient died
4051	11	HDRXJ	prior to Hospital Discharge).
4052	11	HDDRXJ	
40K1	11	HDRXK	
40K2	11	HDDRXK	
40L1	11	HDRXL	
40L2	I1	HDDRXL	
40M1	I1	HDRXM	
40M2	I1	HDDRXM	
40N1	I1	HDRXN	
40N2	11	HDDRXN	
4001	11	HDRXO	
4002	11	HDDRXO	
40P1	11	HDRXP	
40P2	I1	HDDRXP	
41	11	HEPSTOP	1 = Yes, 2 = No
41A	11	HEPDAYS	Days of heparin = 0, 1, 2, 3, 4 or 5
42	11	ORALBB10	1 = Yes, 2 = No
42B	13	ORALBBT	Days from treatment initiation to oral beta-blocker therapy

FORMS 11/12/13
Follow-up Forms
(Variables suffixed by "6W" are from the 6-Week Follow-up Visit.
and variables suffixed by "YE" are from the l-Year Visit.)

ITEM	LENGTH	NAME	CODES
Header of Form 11 or Form 12 or Form 13	11	TYPEFU	Most recent contact recorded was 1 = follow-up visit form 2 = missed visit form 3 = telephone contact form 4 = Hospital discharge form 5 = Death 6 = Search agency
Header of Form 11	11	FU6W, FUYR	1 = Follow-up Visit 0 = No Follow-up Visit
Form 11 # 2 or Form 12 # 2 or Form 13 # 2	14	DAYSFU	Days from treatment initiation to most recent contact
Form 11 # 6	11	PHYACT6W, PHYACTYE	1 -Yes, 2 = No
Form 11 # 7	11	HRTCLS6W, HRTCLSYR	0 = Class 0 1 = Class I 2 = Class II 3 = Class III 4 = Class IV
Form 11 # 9B or Form 12 # 8B	11	CAFV01, CAFV02	1 = Definite 2 = No 3 = Suspect 4 = Unknown
Form 11 # 9C or Form 12 # 8C	11	CHFFV01, CHFFV02	
Form 11 # 9D or Form 12 # 8D	11	PAINFV01, PAINFV02	
Form 11 # 13A	11	FURXA6W, FURXAYR	' 1 -Yes, 2 = No
# 13B	11	FURXB6W, FURXBYR	
# 13C1	11	FURXC16W, FURXC1YR	
# 13C5	11	FURXC56W, FURXC5YR	
# 13D	11	FURXD6W, FURXDYR	
# 13E	11	FURXE6W, FURXEYR	
# 13F	11	FURXF6W, FURXFYR	
# 13G	11	FURXG6W, FURXGYR	
# 13H	11	FURXH6W, FURXHYR	
# 131	11	FURXI6W, FURXIYR	
# 13J	11	FURXJ6W, FURXJYR	
# 13K	11	FURXK6W, FURXKYR	
# 13L	11	FURXL6W, FURXLYR	
# 13M	11	FURXM6W, FURXMYR	
# 13N	11	FURXN6W, FURXNYR	
# 130	11	FURXO6W, FURXOYR	
# 13P	11	FURXP6W, FURXPYR	

FORMS 11/12/13
Follow-up Forms
(Continued)

ITEM	LENGTH	NAME	CODES
Form 12 # 4 or Form 13 # 4	11	LOCATEFU	At most recent follow-up: 1 = able to locate patient 2 = not able
Form 12 # 4B or Form 13 # 4B	11	CCFU	At most recent follow-up: 1 = want Coordinating Center to help locate patient 2 = no help
Form 12 # 7	12	MISS6W, MISSYR	1 = patient ill 2 = patient moved 3 = reason related to study design 4 = reason related to clinic 5 = lack of family or physician support 6 = uncooperative 7 = other 8 = unknown
Form 12 # 12A	11	SOURCE6W, SOURCEYR	1 = patient 2 = spouse/significant other 3 = other kin 4 = patient's doctor 5 = patient's employer 6 = hospital chart 7 = other

FORM 14 (REV 0)
Subsequent Hospitalization Form
(Only Cardiovascular **Rehospitalizations** Extracted)

ITEM		LENGTH	NAME	CODES
2		I4	**HOSCDAY**	Days to hospitalization for cardiovascular reasons (item #7 = 1) from treatment initiation. If # 7 = 0 then HOSCDAY = maximum time to follow-up from Forms 11/12/13/14/15.
7		I1	CHOSC	Censoring variable: 1 = cardiovascular reasons 0 = none
2		14	RHPAINT	Days to first re-hospitalization for definite angina
8A		I1	RHPAIN	Patient was re-hospitalized for definite angina (used to calculate variables in RPIE file) 1 = Yes 0 = No
2		I4	CHFDAY	Days to congestive heart failure from treatment initiation. (Form 10 Item 10 also used). If no CHF, this is time to death or follow-up.
8C		11	CCHF	Censoring variable: 1 = congestive heart failure 0 = none
2		14	ARRDAY	Days from treatment initiation to arrhythmia. If no arrhythmia, this is time to death or follow-up.
8	D	I1	CARR	Censoring variable: 1 = arrhythmia 0 = none
		14	STKDAY	Days from treatment initiation to stroke. (Form 28 also used if category = infarction or hemorrhage (1 or 2). If no stroke, this is time to death or follow-up.
8E		11	CSTK	Censoring variable: 1 = stroke, only if hemorrhage or infarction (on Form 28) or if hospitalized for stroke (Form 14) 0 = none
2		14	**HOSPDAY1**	Days to first re-hospitalization
2		14	STAY1	Length of stay (days) for first re-hospitalization
6		11	**RHEL1**	First re-hospitalization was elective 1 = Yes 2 = No

FORM 14 (REV 0)
Subsequent Hospitalization Form
(Continued)

ITEM	LENGTH	NAME	CODES
8A		RHMI1	
8B		RHANG1	1 = Yes
8C		RHCHF1	2 = No
8D		RHARR1	3 = Suspect
8E	11	RHSTK1	
8F1		RHCATH1	
8F2		RHPTCA1	1 = Yes
8F3		RHCABG1	2 = No
8F4		RHPP1	
8F5		RHOSUR1	
8G		RHOTH1	1 = Yes, 2 = No, 3 = Suspect
2	14	HOSPDAY2	Days to second re-hospitalization
2	14	STAY2	Length of stay (days) for second re-hospitalization
6	11	RHEL2	Second re-hospitalization was elective 1 = Yes 2 = No
8A		RHMI2	
8B		RHANG2	1 = Yes
8C		RHCHF2	2 = No
8D		RHARR2	3 = Suspect
8E	11	RHsTK2	
8F1		RHCATH2	
8F2		RHPTCA2	1 = Yes
8F3		RHCABG2	2 = No
8F4		RHPP2	
8F5		RHOSUR2	
8G		RHOTH2	1 = Yes, 2 = No, 3 = Suspect
2	14	HOSPDAY3	Days to third re-hospitalization
2	I4	STAY3	Length of stay (days) for third re-hospitalization
6	11	RHEL3	Third re-hospitalization was elective 1 = Yes 2 = No
8A		RHMI3	
8B		RHANG3	1 = Yes
8C		RHCHF3	2 = No
8D		RHARR3	3 = Suspect
8E	11	RHSTK3	
8F1		RHCATH3	
8F2		RHPTCA3	1 = Yes
8F3		RHCABG3	2 = No
8F4		RHPP3	
8F5		RHosUR3	
8G		RHOTH3	1 = Yes, 2 = No, 3 = Suspect

FORM 14 (REV 0)
Subsequent Hospitalization Form
(Continued)

ITEM	LENGTH	NAME	CODES
2	I4	HOSPDAY4	Days to fourth re-hospitalization
2	I4	STAY4	Length of stay (days) for fourth re-hospitalization
6	11	RHEL4	Fourth re-hospitalization was elective 1 = Yes 2 = No
8A	11	RHMI4	1 = Yes 2 = No 3 = Suspect
8B		RHANG4	
8C		RHCHF4	
8D		RHARR4	
8E		RHSTK4	
8F1		RHCATH4	1 = Yes 2 = No
8F2		RHPTCA4	
8F3		RHCABG4	
8F4		RHPP4	
8F5		RHOSUR4	
8G		RHOTH4	1 = Yes, 2 = No, 3 = Suspect
2	14	HOSPDAY5	Days to fifth re-hospitalization
2	I4	STAY5	Length of stay (days) for fifth re-hospitalization
6	11	RHEL5	Fifth re-hospitalization was elective 1 = Yes 2 = No
8A	11	RHM15	1 = Yes 2 = No 3 = Suspect
8B		RHANG5	
8C		RHCHF5	
8D		RHARR5	
8E		RHSTK5	
8F1		RHCATH5	1 = Yes 2 = No
8F2		RHPTCA5	
8F3		RHCABG5	
8F4		RHPP5	
8F5		RHosUR5	
8G		RHOTH5	1 = Yes, 2 = No, 3 = Suspect
CALCULATED	11	FORM14_1	Total number of Form 14's received for a patient (only cardiovascular re-hospitalizations)
CALCULATED	I1	FORM14_2	1 = Second Form 14 received
CALCULATED	11	FORM14_3	1 = Third Form 14 received
CALCULATED	11	FORM14_4	1 = Fourth Form 14 received
CALCULATED	11	FORM14_5	1 = Fifth Form 14 received

FORM 15 (REV 0)
Death Notification Form

ITEM	LENGTH	NAME	CODES
	11	FORM15	1 = Form received
S	12	F15CAUSE	Tentative cause of death 1 = Qualifying MI 2 = New MI, confirmed or suspected 3 = Sudden coronary death - arrhythmia suspected 4 = Congestive heart failure S = Confirmed cardiac arrhythmia 6 = Peri-operative cardiovascular surgical death 7 = Stroke 8 = Non-cardiac, non-cerebral, atherosclerotic arterial disease 9 = Pulmonary embolism 10 = Non-atherosclerotic heart disease 11 = Neoplastic disease 12 = All other diseases 13 = Non-cardiovascular surgically related death 14 = Homicide, suicide, accident 1s = Unknown

FORM 16 (REV 0)
Cause of Death Form

ITEM	LENGTH	NAME	CODES
	11	FORM16	**1** = Form received
16	11	AUTOPSY	1 = **Yes,** 2 -No

FORM 17 (REV 2, 3)
MMCC Death Classification Form

ITEM	LENGTH	NAME	CODES
Header	11	DEATH	1 = Patient died (at any time) 0 = Patient alive
2	F10.5	DTIME	Time (days) from treatment initiation to death (if missing Form 15 is used). If patient has not died, this is days of follow-up.
2	14	DDAYS	Integer days from treatment initiation to death. If patient has not died, this is days of follow-up.
6A	11	DCOMP	1 = natural causes 2 = complications
6B	11	DHEMORR	1 -Yes, 2 -No
6C	I1	DPTCA	1 = Yes, 2 = No
6D	11	DCABG	1 -Yes, 2 = No
6E	11	DOTHER	1 = Yes, 2 -No
7	11	DCVD	1 = Yes, 2 = No
8A	11	DCARDIAC	1 = Yes, 2 = No
8B/8B1	11	F17MI	0 = No or unknown 1 = Qualifying MI 2 = Recurrent MI
8B2	11	F17TIME	If DCOMP = 1: 1 = Before any procedures 2 = After any procedures 3 = No procedures performed If DCOMP = 2: 1 = Before any complications 2 = After any complications
8C	11	DPMPFAIL	1 = Yes, 2 = No
	11	DVENTRUP	
	I1	DARRTH	
	11	DOTHCAR	
15	F6.1	DICDCODE	ICD code

FORM 19 (REV 0) - PARTS 1, 2, 3, 4, 5, 6-15(a-e)
Laboratory Data Form

ITEM	LENGTH	NAME	CODES
3	15	ULCK	IV/L
3A	F10.5	CKTIM000	
3B	F10.5	CKTIM004	
3c	F10.5	CKTIM008	
3D	F10.5	CKTIM012	
3E	F10.5	CKTIM016	
3F	F10.5	CKTIM020	
3G	F10.5	CKTIM024	
3H	F10.5	CKTIM030	
31	F10.5	CKTIM036	Time from treatment initiation (days)
3J	F10.5	CKTIM042	
3K	F10.5	CKTIM048	
3L	F10.5	CKTIM072	
3M	F10.5	CKTIM096	
3N	F10.5	CKTIM120	
30	F10.5	CKTIM144	
3P	F10.5	CKTIM168	
3Q	F10.5	CKTIM192	
3R	F10.5	CKTIM216	
3s	F10.5	CKTIM240	
3A	15	CKTOT000	
3B	15	CKTOT004	
3c	15	CKTOT008	
3D	15	CKTOT012	
3E	15	CKTOT016	
3F	15	CKTOT020	
3G	15	CKTOT024	
3H	15	CKTOT030	
31	15	CKTOT036	IU/L
3J	15	CKTOT042	
3K	15	CKTOT048	
3L	15	CKTOT072	
3M	15	CKTOT096	
3N	15	CKTOT120	
30	15	CKTOT144	
3P	15	CKTOT168	
3Q	15	CKTOT192	
3R	15	CKTOT216	
3s	15	CKTOT240	
6A	15, I1	HEP19D01, IVD01	
7A	15, I1	HEP19D02, IVD02	
8A	15, 11	HEP19D03, IVD03	
9A	15, I1	HEP19D04, IVD04	U USP, 1 = IV
10A	15, I1	HEP19D05, IVD05	2 = Subcu
11A	15, I1	HEP19D06, IVD06	3 = Both
12A	15, I1	HEP19D07, IVD07	0 = None
13A	15, I1	HEP19D08, IVD08	
14A	15, 11	HEP19D09, IVD09	
15A	15, I1	HEP19D10, IVD10	

FORM 19 (REV 0) - PARTS 1, 2, 3, 4, 5, 6-15(a-e)
Laboratory Data Form
(Continued)

ITEM	LENGTH	NAME	CODES
6B	I4	ASA19D01	
7B	14	ASA19D02	
8B	I4	ASA19D03	
9B	I4	ASA19D04	
10B	I4	ASA19D05	mg
11B	14	ASA19D06	
12B	14	ASA19D07	
13B	14	ASA19D08	
14B	14	ASA19D09	
15B	14	ASA19D10	
6C	F4.1	COU19D01	
7c	F4.1	COU19D02	
8C	F4.1	COU19D03	
9C	F4.1	COU19D04	
10C	F4.1	COU19D05	mg
11C	F4.1	COU19D06	
12C	F4.1	COU19D07	
13c	F4.1	COU19D08	
14C	F4.1	COU19D09	
15c	F4.1	COU19D10	
6D	13	MET19D01	
7D	13	MET19D02	
8D	13	MET19D03	
9D	13	MET19D04	
10D	13	MET19D05	mg
11D	13	MET19D06	
12D	13	MET19D07	
13D	13	MET19D08	
14D	13	MET19D09	
15D	13	MET19D10	
6E	11	OBBD01	
7E	11	OBBD02	
8E	11	0BBD03	
9E	11	OBBD04	
10E	11	0BBD05	1 = Yes, 2 = No
11E	I1	0BBD06	
12E	11	OBBD07	
13E	11	0BBD08	
14E	11	OBBD09	
15E	11	OBBD10	

FORM 23 (REV 0, 1, 2)
Myocardial Infarction Event Form

ITEM	LENGTH	NAME	CODES
	I1	FORM23	1 = At least 1 Form 23 received
	I1	F23_1 F23_2 F23_3 F23_4 F23_5	1 = First Form 23 1 = Second Form 23 1 = Third Form 23 1 = Fourth Form 23 1 = Fifth Form 23 } on FORM14.SSD
2	F10.5	MIDATE, MIDATE2, MIDATE3	Time (days) from treatment initiation to classified MI (used only if Form 43 # 2 is missing)
CALCULATED	I1	CLINICMI	Total number of Form 23's received for a patient (0, 1, 2, . ..)
3B	I1	F23PAIN1 F23PAIN2 F23PAIN3 F23PAIN4 F23PAIN5	Pain indicated on first Form 23 Pain indicated on second Form 23 Pain indicated on third Form 23 Pain indicated on fourth Form 23 Pain indicated on fifth Form 23
	14	F23PNT1 F23PNT2 F23PNT3 F23PNT4 F23PNT5	Days to pain identified above. (Missing if no pain)
CALCULATED	12	PAIN23	Pain indicated on at least one Form 23
CALCULATED	14	PAIN23T	Time to first recording of pain on Form 23

RECURRENT PAINFUL ISCHEMIC EVENTS (R.P.I.E.)
(Defined from Forms 10, 23, 43 and 14)

LENGTH	NAME	CODES
11	RPIEHD	First in hospital R.P.I.E. was 1 = Definite MI 2 = Suspect MI 3 = Pain recorded on Form 10 Item 15 0 = No event
13	RPIEHDT	Time to first in-hospital event (days). If no event, this is missing.
I1	RPIE	First R.P.I.E. was 1 = Definite MI 2 = Suspect MI 3 = Rehospitalized for definite angina (Form 14) 0 = No event
13	RPIET	Time to first event (days). If no event, this is missing.
11	RPIEAFT	First R.P.I.E. after hospital discharge was 1 = Definite MI 2 = Suspect MI 3 = Rehospitalized for definite angina (Form 14) 0 = No event
I3	RPIEAFTT	Time to first event after hospital discharge (days). If no event, this is missing.
I1	DSMI	1 = Definite or suspect MI 0 = None
13	DSMIT	Time to first definite or suspect MI (days). If no event, this is missing.

FORM 24 (REV 0, 1)/44 (REV 0, 1)

There are six "sets" of variables (suffixed by 1, 2, 3, 4, 5 or 6) -- each is based on a different subgroup of events (Form 44 #4A).

1. Patient's first major event
2. Patient's first major or minor event
3. Patient's first major, minor or loss no site event
4. Same as #1, but only nonsurgical events*
5. Same as #2, but only nonsurgical events*
6. Same as #3, but only nonsurgical events*
7. Same as #1, but only surgical events
8. Same as #2, but only surgical events
9. Same as #3, but only surgical events

*Nonsurgical events: Form 44 # 4B = 2. All loss no site events are nonsurgical.

ITEM	LENGTH	NAME	CODES
	I1	FORM44	1 = At least 1 Form 44 received
Form 44 # 2	F10.5	HEMTIME1-9	Time (days) from treatment initiation to event. If no event, then this is days to hospital discharge or death prior to hospital discharge.
		.	
Form 44 # 4A	I1	HEMSEV1, HEMSEV4, HEMSEV7	0 = none or missing 1 = major
	I1	HEMSEV2, HEMSEV5, HEMSEV8	0 = none or missing 1 = major 2 = minor
	I1	HEMSEV3, HEMSEV6, HEMSEV9	0 = none or missing 1 = major 2 = minor 4 = loss no site

FORM 24 (REV 0, 1)/44 (REV 0, 1)
(Continued)

ITEM	LENGTH	NAME	CODES
Form 44 #8	11	LT24_1-9	1 = Event occurred within 24 hours of rt-PA initiation 2 = Event did not occur within 24 hours of rt-PA initiation 0 = Loss no site (question not answered)
CALCULATED	11	SEVTOT1	Total number of major events for a patient
CALCULATED	11	SEVTOT2	Total number of minor events for a patient
CALCULATED	11	SEVTOT3	Total number of no events for a patient
CALCULATED	I1	SEVTOT4	Total number of loss no sites for a patient
Form 44 # 5A, 5B	12	HEMPRIM1-9	0 = no event 1 = gastrointestinal 2 = intracranial 3 = catheter site 4 - other puncture site 5 - genitourinary 6 = retroperitoneal 7 = other 8 = unknown (includes loss no site) 10 = two or more secondary sites
Form 24 # 13	11	HEMTRNS1-9	1 = yes 2 = no
Form 10 # 2	13	HDDAY	Days from treatment initiation to hospital discharge
Form 17 #6B	I1	HEMDEATH	1 = Death from hemorrhage prior to hospital discharge 2 = Other cause of death
CALCULATED	F10.5	HEMTIME	Time of HERC* event
CALCULATED	I1	HEMSEV	Severity of HERC* event 1 = No event 2 = Major 3 = Minor 4 = Loss, no site

*Most severe, nonsurgical event (defined by M. Terrin for HERC Manuscript).

FORM 24 (REV 0, 1)/44 (REV 0, 1)
(Continued)

ITEM	LENGTH	NAME	CODES
CALCULATED	12	HEMPRIM	Site of HERC* event 0 = no event 1 = gastrointestinal 2 = intracranial 3 = catheter site 4 = other puncture site 5 = genitourinary 6 = retroperitoneal 7 = other 8 = unknown (includes loss no site) 10 = two or more secondary sites

*Most severe, nonsurgical event (defined by M. Terrin for HERC Manuscript).

FORM 25 (REV 0, 1)
Cardiac Surgery Form

If more than one event, data from first event is used
(except for SURGTIM2)

ITEM	LENGTH	NAME	CODES
	11	FORM25	Number of Form 25's received
2	F10.5	SURGTIME	Days from treatment initiation to first event
2	F10.5	SURGTIM2	Days from treatment initiation to second event
4, 4A	11	SURGREAS	0 = elective 1 = angina without definite ECG changes 2 = angina with ECG changes 3 - persistent chest pain and ST elevation 4 = other
5A	I1	ANGSTAT	1 = Definite angina 2 = Probable angina 3 = Probably not angina 4 - No angina
5B	I1	ANGCLASS	0 = 0 1 = I 2 = II 3 = III 4 = IV
5c	I1	ANGPAIN	1 = Yes, 2 = No
6	I1	F25EXER	1 = Yes, 2 = No
6A	13	F25PULSE	beats/min
6B1	13	F25SYSTO	mm Hg
6B2	13	F25DIAST	mm Hg
7	I1	F25CATH	1 = Yes, 2 = No
8A/8B	I1	LADGRAFT	1 = LAD/diagonal 2 = other
8C/8D	I1	CXGRAFT	1 = CX/obtuse marginal 2 = other
8E	I1	RCAGRAFT	1 = RCA or RPDA 2 = other
8F	I1	LMCGRAFT	1 = LMCA 2 = other

FORM 25 (REV 0, 1)
Cardiac Surgery Form
(Continued)

If more than one event, data from first event is used
(except for **SURGTIM2**)

ITEM	LENGTH	NAME	CODES
9A	I1	CONDSAP	1 = Conduit used
9B	I1	CONDLIM	
9C	11	CONDRIM	
9D	11	CONDOTH	
10A	I1	F25DEATH	Death within 24 hours of CABG 1 = Yes, 2 = No (calculated from events)
10B	I1	F25MI	MI within 24 hours of CABG 1 = Yes, 2 = No (calculated from events)
11	I1	F25TRANS	1 = Yes, 2 = No (Rev 1 only)

FORM 26 (REV 0)
Transfusion Report Form

ITEM	LENGTH	NAME	CODES
	I1	FORM26	1 = Form received
	F10.5	TRANTIME	Days from treatment initiation to first transfusion (if no transfusion, this is days to hospital discharge)
3A	I1	F26HEM	0 = No, l-Yes
3B	I1	F26SURG	0 = No, 1 = Yes
3c	I1	F26ANEM	0 = No, 1 = Yes
3D	I1	F26OTH	0 = No, 1 = Yes
4A	F4.1	F26WBU	Number of units. If missing Form 24 # 14A is used.
4B	F4.1	F26PCU	Number of units. If missing Form 24 # 14B is used.
CALCULATED	F5.1	TFUNIT	F26WBU + F26PCU

FORM 27 (REV 0)
Severe Neurologic Event Form

ITEM	LENGTH	NAME	CODES
6	11	ALCOH	Alcohol consumption 1 = ≤ 1 oz 2 = 2-3 oz 3 = 4-5 oz 4 = ≥ 6 oz 5 = unknown
11A	12	EPMO	Earliest date and time of symptoms
	12	EPDA	
	12	EPYR	
	12	EPHR	
		EPMN	
11B	12	LPMO	Latest date and time of symptoms
	12	LPDA	
	12	LPYR	
	I2	LPHR	
	12	LPMN	
12A	11	ITEM12A	Severe headache
	11	ITEM12B	Vomiting
	I1	ITEM12C	Seizures
	11	ITEM12D	Focal deficit
	11	ITEM12E	Altered mental
	11	ITEM12F	Coma
			1 = Yes 2 = No 3 = Unknown
13	11	ITEM13	Onset was: 1 = Sudden 2 = Steplike 3 = Gradual 4 = Unknown
14	11	ITEM14	Maximum deficit achieved 1 = ≤ 6 hours 2 - 7-12 hours 3 = 13-24 hours 4 = 25-48 hours 5 = 49-72 hours 6 = > 72 hours 7 = Unknown
15	11	ITEM15	Improvement 1 = Yes, 2 = No, 3 = Unknown
16	11	ITEM16	Change in blood pressure 1 = Yes, 2 = No, 3 = Unknown
16A	11	ITEM16A	Hypotension 1 = Yes, 2 = No, 3 = Unknown
16B	11	ITEM16B	Hypertension 1 = Yes, 2 = No, 3 = Unknown

FORM 27 (REV 0)
Severe Neurologic Event Form
(Continued)

ITEM	LENGTH	NAME	CODES
17A	I1	ITEM17A	Antiplatelet agents
17B	I1	ITEM17B	Calcium channel blockers
17c	I1	ITEM17C	Ergotamines
17D	I1	ITEM17D	IV nitroglycerine
18A	I1	ITEM18A	Profound hypotension
18B	I1	ITEM18B	Fluctuations in systolic BP
18C	I1	ITEM18C	Arrhythmias

1 = Yes
2 = No
3 = Unknown

19	I1	ITEM19	Verbal response 1 = Oriented and converses 2 - Disoriented/confused 3 = Inappropriate words 4 = Incomprehensible sounds 5 = None 6 = Untested
20	I1	ITEM20	Eye opening 1 = Spontaneous 2 = To speech 3 - To pain 4 = None 5 = Untested
21	I1	ITEM21	Motor response 1 = Obeys 2 - Localizes 3 = Withdraws 4 = Abnormal flexion 5 = Abnormal extension 6 - None 7 - Untested
46	I1	ITEM46	CT scan evidence of lesion 1 - Yes, 2 - No, 3 = Unknown, 4 = Not done
46A	I1	ITEM46A	Deep lacunar infarction
46B	I1	ITEM46B	Cortical infarction
46C	I1	ITEM46C	Larger infarction
46D	I1	ITEM46D	Mottled hemorrhagic infarction
46E	I1	ITEM46E	Subarachnoid hemorrhage
46F	I1	ITEM46F	Intraparenchymal hemorrhage
46G	I1	ITEM46G	Watershed area infarction
46H	I1	ITEM46H	More than one infarction

1 - Yes
2 - No
3 - Unknown

53	I1	ITEM53	Recovery 1 = Full, no deficit 2 = Partial, minor residual 3 = Partial, major residual 4 = Comatose 5 = Deceased

FORM 28 (REV 0)
Severe Neurologic Event Classification Form

ITEM	LENGTH	NAME	CODES
2	16	F28DATE	Date of event
3A	11	ITEM3A	Infarction
3B	11	ITEM3B	Hemorrhage
3c	I1	ITEM3C	TIA
3D	11	ITEM3D	Other
			1 = Yes 2 = No
4A	12	ITEM4A	Primary cerebral site
4B	12	ITEM4B	Other cerebral
4c	12	ITEM4C	Other cerebral
4D	12	ITEM4D	Other cerebral
4E	12	ITEM4E	Other cerebral
4F	11	ITEM4F	More than 5 sites 1 = Yes, 2 = No
5A	12	ITEM5A	Primary vascular territory
5B	12	ITEM5B	Other vascular
5c	12	ITEM5C	Other vascular
5D	12	ITEM5D	Other vascular
5E	12	ITEM5E	Other vascular
5F	11	ITEM5F	More than 5 territories 1 = Yes, 2 = No
6	11	ITEM6	Hours to onset 1 = ≤ 12 hours 2 = 12-23 hours 3 = 24-71 hours 4 = ≥ 72 hours
7A	11	ITEM7A	Lacune
7B	11	ITEM7B	Embolism
7c	11	ITEM7C	Thrombosis
7E	11	ITEM7E	Unknown
			1 = Yes 2 = No
8A	11	ITEM8A	Subdural
8B	11	ITEM8B	Parenchym
8C	11	ITEM8C	Subarachnoid
8D	11	ITEM8D	Epidural
			1 = Yes 2 = No
9A	11	ITEM9A	Subdural
9B	11	ITEM9B	Parenchym
9C	11	ITEM9C	Subarachnoid
9D	11	ITEM9D	Epidural
			1 = Yes 2 = No
10	I1	ITEM10	Hemorrhage in infarct 1 = Yes 2 = No

FORM 28 (REV 0)
Severe Neurologic Event Classification Form
(Continued)

ITEM	LENGTH	NAME	CODES
11A	11	ITEM11A	t-PA
11B	11	ITEM11B	Heparin controlled
11C	11	ITEM11C	Heparin not documented
11D	I1	ITEM11D	Coumadin controlled
11E	I1	ITEM11E	Coumadin not documented
11F	11	ITEM11F	Embolism
11G	I1	ITEM11G	Hypotension
11H	I1	ITEM11H	Hypertension
11I	I1	ITEM111	Trauma
11J	I1	ITEM11J	Aortic balloon pump
11K	I1	ITEM11K	PTCA
11L	I1	ITEM11L	Surgery
11M	11	ITEM11M	Vascular malformation
11N	I1	ITEM11N	Other

1 = Primary
2 = Secondary
3 = Not at all

CALCULATED	I1	STKCAT	Type of neurological events: 1 = Hemorrhage 2 = Infarct 3 = TIA 4 = Subdural

FORM 31 (REV 0)
Catheterization and PTCA During Initial Hospitalization

ITEM	LENGTH	NAME	CODES
5	11	PTO1DONE	Protocol Cath Done 1 = Yes, 2 = No
5	11	PTO2DONE	Hospital Discharge Cath Done 1 = Yes, 2 = No
9	11	PTCADONE	Protocol PTCA Done 1 = Yes, 2 = No, 3 = Attempted
10	12	PTCAREAS	Reasons why Protocol PTCA was not performed 1 = Patient deceased 2 = Patient refused 3 = Physician refused 4 = Emergency CABG 5 = Emergency PTCA 6 = Other emergency procedure 7 = Total occlusion 8 = Stenosis < 60% 9 = Distal lesions 10 = Lesion too long (> 20 mm) 11 = Lesion involves bifurcation of major coronary branches 12 = Tortuous proximal vessel 13 = Infarct related lesion is in LMCA 14 = Stenosis > 70% in LMCA 15 = Closure of IRA at the site of stenosis would result in severe hemodynamic collapse 16 = Bleeding complications 17 = Complication of catheterization 18 = Cath lab not available 19 = PTCA physician not available 20 = Surgical backup not available 21 = Other

FORM 39 (REV 0)
Bicycle Ergometry Test Form (Clinic)
Data collected at Hospital Discharge (HD) and 6 weeks (6W)

ITEM	LENGTH	NAME	CODES
5	12	REASHD, REAS6W	Reason for stopping test 1 = Chest pain 2 = ST-segment change 3 = Arrhythmia - supraventricular 4 = Arrhythmia - ventricular 5 = Hypertension 6 = Hypotension 7 = Fatigue/exhaustion 8 = Dyspnea 9 = Dizziness 10 = Poor motivation 11 = Physician's request 12 = Patient completed protocol 13 = Adequate HR achieved 14 = Claudication
6A	I1	NITRTHD, NITRT6W	1 -Yes, 2 = No
6B	I1	BBHD, BB6W	
6C	I1	CABLCKHD, CABLCK6W	
6D	I1	ANTIAHD, ANTIA6W	
6E	11	DIURETHD, DIURET6W	
6F	11	DIGITHD, DIGIT6W	
7	14	BTIMEHD, BTIME6W	Seconds
8	14	LEVELHD, LEVEL6W	kpm
9	13	PMAXHRHD, PMAXHR6W	%
10A*	13	RSTHRHD, RSTHR6W	beats/minute
	13	RSTSBPHD, RSTSBP6W	mm Hg
	13	RSTDBPHD, RSTDBP6W	mm Hg
10B*	13	EXHRHD, EXHR6W	beats/minute
	13	EXSBPHD, EXSBP6W	mm Hg
	13	EXDBPHD, EXDBP6W	mm Hg
10C*	13	RECHRHD, RECHR6W	beats/minute
	13	RECSBPHD, RECSBP6W	mm Hg
	13	RECDBPHD, RECDBP6W	mm Hg
11*	11	EXPAINHD, EXPAIN6W	1 = Yes, 2 = No
11A	11	PAINTHD, PAINT6W	0 = No pain, 1 = angina, 2 = atypical chest pain
12	I1	SBPDECHD, SBPDEC6W	1 = Yes, 2 = No
12A	13	SBPMCHHD, SBPMCH6W	mm Hg
13*	11	HRDECHD, HRDEC6W	1 -Yes, 2 = No
13A*	13	HRMCHHD, HRMCH6W	beats/minute

FORM 39 (REV 0)
Bicycle Ergometry Test Form (Clinic)
Data collected at Hospital Discharge (HD) and 6 weeks (6W)
(Continued)

ITEM	LENGTH	NAME	CODES
14A	11	LBBBHD, LBBB6W	1 -Yes, 2 = No
14B	11	RBBBHD, RBBB6W	
14C	11	LVHHD, LVH6W	
14D	11	STEHD, STE6W	
15	11	RSTSTDHD, RSTSTD6W	1 = Yes, 2 = No
16	11	EXSTDHD, EXSTD6W	1 -Yes, 2 -No
18A	F3.1	EXSTDDHD, EXSTDD6W	mm
	11	EXCFHD, EXCF6W	1, 2 or 3
18B	F3.1	RECSTDHD, RECSTD6W	mm
	11	RECCFHD, RECCF6W	1, 2 or 3
20	12	LEADSHD, LEADS6W	Number of leads
21	12	STDLDHD, STDLD6W	Number of leads
22	11	EXSTEHD, EXSTE6W	1 = Yes, 2 -No
23A	F3.1	STEQHD, STEQ6W	mm
23B	F3.1	STENQHD, STENQ6W	mm
24A	11	IPVCNHD, IPVCN6W	1 = Yes
		IPVCRHD, IPVCR6W	
		IPVCEHD, IPVCE6W	
		IPVCRCHD, IPVCRC6W	
24B	11	FPVCNHD, FPVCN6W	
		FPVCRHD, FPVCR6W	
		FPVCEHD, FPVCE6W	
		FPVCRCHD, FPVCRC6W	
24C	11	VCPNHD, VCPN6W	
		VCPRHD, VCPR6W	
		VCPEHD, VCPE6W	
		VCPRCHD, VCPRC6W	
24D	I1	VTCHNDH, VTCHN6W	
		VTCHRHD, VTCHR6W	
		VTCHEHD, VTCHE6W	
		VTCHRCHD, VTCHRC6W	

*If missing or not available Form 8A is used.

FORM 40 (REV 0,1)
One Year Treadmill Exercise Test Form

ITEM	LENGTH	NAME	CODES
	11	FORM40	1 = Form received
2	I4	F40DAYS	Days to 1 year exercise test
5	12	REASYR	Primary reason for stopping test 1 = Chest pain 2 = ST-segment change 3 = Arrythmia - supraventricular 4 = Arrythmia - ventricular 5 = Hypertension 6 = Hypotension 7 = Fatigue/exhaustion 8 = Dypsnea 9 = Dizziness 10 = Poor motivation 11 = Physician's request 12 = Patient completed protocol 13 = Adequate HR achieved 14 = Claudication
	14	TTIMEYR	Seconds
	12	FSTAGEYR	Final exercise stage 1 - o 2 = 1/2 3 = I 4 = II 5 = III 6 = IV 7 = V 8 = VI 9 = VII
9	I3	PMAXHRYR	%
10A	I3	RSTHRYR	beats/minute
	I3	RSTSBPYR	mm Hg
	I3	RSTDBPYR	mm Hg
10B	I3	EXHRYR	beats/minute
	I3	EXSBPYR	mm Hg
	I3	EXDBPYR	mm Hg
10C	I3	RECHRYR	beats/minute
	I3	RECSBPYR	mm Hg
	I3	RECDBPYR	mm Hg
11	I1	EXPAINYR	1 = Yes, 2 = No
12	I1	PAINTYR	1 = Angina, 2 = Atypical
13	I1	SBPDECYR	1 -Yes, 2 -No
14	I3	SBPMCHYR	mm Hg

FORM 40 (REV 0, 1)
One Year Treadmill Exercise Test Form
(Continued)

ITEM	LENGTH	NAME	CODES
15A	11	LBBBYR	1 -Yes, 2 = No
15B	11	RBBBYR	
15c	11	LVHYR	
15D	11	STEYR	
16	11	RSTSTDYR	1 =Yes, 2 = No
17	F3.1	STDMCHYR	mm
18	13	EXSTDYR	1 = Yes, 2 = No
19A	F3.1	EXSTDDYR	mm
	11	EXCFYR	1, 2 or 3
19B	F3.1	RCSTDDYR	mm
	11	RECCFYR	1, 2 or 3
20	11	ONSTGYR	Exercise stage (0-7)
21	12	STDLDYR	Number of leads
22	11	EXSTEYR	1 = Yes, 2 = No
23A	F3.1	STEQYR	mm
23B	F3.1	STENQYR	mm
CALCULATED	I1	RESULTYR	1 = Severe ischemia (Definition 2 = Ischemia supplied by 3 = Normal Dr. Chaitman) 4 = Non-diagnostic If result could not be assessed due to missing data, the clinic interpretation was used (Items 27 and 28)

FORM 41 (REV 1)
One Year Treadmill Exercise Test Non-Performance Form

ITEM	LENGTH	NAME	CODES
	11	FORM41	1 = Form received
3	12	F41REAS	1 = Resting angina 2 = Other cardiac disease 3 = Peripheral vascular disease 4 = Musculoskeletal reasons 5 = Patient refused 6 = Moved/lost to follow-up 7 = Treadmill test performed within past three months 8 = Different test performed (not Bruce Protocol) 9 = Physician refused 10 = Protocol violation 11 = No funds for payment 12 = Other

FORM 43 (REV 1)
MMCC Myocardial Infarction Event Classification Form

Only events that were classified as an event, i.e., must have
Form 43 #4 = 1 or Form 17 # 8B1 = 2,
or Form 15 # 5 = 2 (if Form 17 missing)

ITEM	LENGTH	NAME	CODES
	11	FORM43	1 = At least one Form 43 received
2 (or Form 17 #2 if Form 17 #8B1 = 2, or Form 15 #2 if Form 17 is missing and Form 15 #5 = 2)	F10.5	MIDATE	Time (days) from treatment initiation to first recurrent MI (if no MI then this is days to death or follow-up)
(same as MIDATE)	F10.5	MIDATE2	Time (days) from treatment initiation to second recurrent MI (if no second MI then this is missing)
(same as MIDATE)	F10.5	MIDATE3	Time (days) from treatment initiation to third recurrent MI (if no third MI then this is missing)
CALCULATED	14	MIDAYS	Integer days to first recurrent MI
CALCULATED	I1	MITYPE	0 = no MI 1 = recurrent MI (Form 43 #4 = 1, or Form 17 # 8B1 = 2, or Form 17 # 8B1 is missing and Form 15 #5 = 2)
CALCULATED	11	MMCCMI	Total number of classified nonfatal MI's (Form 43) for a patient (0, 1, 2, . ..)
CALCULATED	I1	FATALMI	1 = Yes, 0 = No
CALCULATED	11	NONFATMI	1 = Yes, 0 = No

FORM 43 (REV 2)
MMCC Myocardial Infarction Event Classification Form

Only events that were classified as an event, i.e., must have Form 43 #5D = 1 or Form 43 # 6 A = 1, or Form 17 #8B1 = 2 or Form 15 #5 = 2 (if Form 17 missing))

ITEM	LENGTH	NAME	CODES
	11	FORM43	1 = At least one Form 43 received
2 (or Form 17 #2 if Form 17 #8B1 = 2 or Form 15 #2 if Form 17 is missing and Form 15 #5 = 2)	F10.5	MIDATE	Time (days) from treatment initiation to first recurrent MI (if no MI then this is days to death or follow-up)
(same as MIDATE)	F10.5	MIDATE2	Time (days) from treatment initiation to second recurrent MI (if no second MI then this is missing)
(same as MIDATE)	F10.5	MIDATE3	Time (days) from treatment initiation to third recurrent MI (if no third MI then this is missing)
CALCULATED	14	MIDAYS	Integer days to first recurrent MI
4	11	F43TIME	1 = < 18 hours 2 = ≥ 18 hours If Rev 1, assigned a "2" If no MI, assigned a "0"
CALCULATED	11	MITYPE	0 = No MI 1 = Recurrent MI (Form 43 #5D = 1 or Form 43 #6A = 1, or Form 17 # 8B1 = 2, or Form 17 # 8B1 is missing and Form 15 # 5 = 2)
CALCULATED	11	MMCCMI	Total number of classified nonfatal MI's (Form 43) for a patient (0, 1, 2, . ..)
CALCULATED	11	FATALMI	0 = No, 1 = Yes
CALCULATED	11	NONFATMI	0 = No, 1 = Yes

QUALIFYING ECG FILE

LENGTH	NAME	CODES
11	FILEECG	1 = ECG received
12	ECGNUM	ECG number
16	SEQNUM	Sequence number
17	MEANRR	Mean RR interval (msec)
17	PRINTER	PR interval (msec)
17	QAMPLI	Q amplitude
17	QAMPLII	
17	QAMPLIII	
17	QAMPLAVR	
17	QAMPLAVL	
17	QAMPLAVF	
17	QAMPLV1	
17	QAMPLV2	
17	QAMPLV3	
17	QAMPLV4	
17	QAMPLV5	
17	QAMPLV6	
17	RAMPLI	R amplitude
17	RAMPLII	
17	RAMPLIII	
17	RAMPLAVR	
17	RAMPLAVL	
17	RAMPLAVF	
17	RAMPLV1	
17	RAMPLV2	
17	RAMPLV3	
17	RAMPLV4	
17	RAMPLV5	
17	RAMPLV6	
17	STDVLI	ST deviation (+ value = ST elevation - value = ST depression)
17	STDVLII	
17	STDVLIII	
17	STDVLAVR	
17	STDVLAVL	
17	STDVLAVF	
17	STDVLV1	
17	STDVLV2	
17	STDVLV3	
17	STDVLV4	
17	STDVLV5	
17	STDVLV6	

FILE GT
Coagulation Core Lab Data
(RED TUBES ONLY)

LENGTH	NAME	CODES
15	PLSPRER	Blank if missing
15	PLS50MNR	
I5	PLS5HRR	
15	PLS8HRR	
13	FIBPRER	Blank if missing
13	FIB50MNR	
13	FIB5HRR	
13	FIB8HRR	
I5	TPAPRER	Blank if missing
15	TPA50MNR	
15	TPA5HRR	
15	TPA8HRR	
17	FDPPRER	Blank if missing
17	FDP50MNR	
I7	FDP5HRR	
17	FDP8HRR	
I5	ALPPRER	Blank if missing
15	ALP50MNR	
15	ALP5HRR	
15	ALP8HRR	

FILE LV

CONTRAST LEFT VENTRICULOGRAPHY

LENGTH	NAME	CODES
11	DISCAT	1 = Single LAD 2 = Multi LAD 3 = Single RCA 4 = Multi RCA 5 = Undefined
I1	FLV01	1 = LV data available for protocol catheterization 0 = no data
14	EDV	End diastolic volume
14	ESV	End systolic volume
14	STKV	Stroke volume
F5.1	co	Cardiac output
14	RVGEF01	Ejection fraction
F10.4	POSLAD	Hypokinesis single vessel LAD
F10.4	POMLAD	Hypokinesis multiple vessel LAD
F10.4	POSRCA	Hypokinesis single vessel RCA
F10.4	POMRCA	Hypokinesis multiple vessel RCA
F10.4	PERSLAD	Hyperkinesis single vessel LAD
F10.4	PERMLAD	Hyperkinesis multiple vessel LAD
F10.4	PERSRCA	Hyperkinesis single vessel RCA
F10.4	PERMRCA	Hyperkinesis multiple vessel RCA
12	YEAR01	Date of protocol cath
12	MONTH01	
12	DAY01	
F10.4	HYPO	Hypokinesis protocol
F10.4	HYPER	Hyperkinesis protocol
13	ONESD	Length of segment with hypokinesis more than -1 SD (NL1L)
13	TWOSD	Length of segment with hypokinesis more than -2 SD (NL2L)
I3	CHORDS	Length of segment with akinesis or dyskinesis (NLOL)
I1	FLVHD	1 = LV data available for HD catheterization 0 = no data
14	EDVHD	End diastolic volume
14	ESVHD	End systolic volume
14	STKVHD	Stroke volume
F5.1	COHD	Cardiac output
14	RVGEFHD	Ejection fraction
F10.4	POSLADHD	Hypokinesis single vessel LAD
F10.4	POMLADHD	Hypokinesis multiple vessel LAD
F10.4	POSRCAHD	Hypokinesis single vessel RCA
F10.4	POMRCAHD	Hypokinesis multiple vessel RCA
F10.4	PRSLADHD	Hyperkinesis single vessel LAD
F10.4	PRMLADHD	Hyperkinesis multiple vessel LAD
F10.4	PRSRCAHD	Hyperkinesis single vessel RCA
F10.4	PRMRCAHD	Hyperkinesis multiple vessel RCA

FILE LV

CONTRAST LEFT VENTRICULOGRAPHY
(Continued)

LENGTH	NAME	CODES
12	YEARHD	Date of HD cath
12	MONTHHD	
12	DAYHD	
F10.4	HYPOHD	Hypokinesis HD
F10.4	HYPERHD	Hyperkinesis HD
13	ONESDHD	Length of segment with hypokinesis more than -1 SD (NL1L)
13	TWOSDHD	Length of segment with hypokinesis more than -2 SD (NL2L)
13	CHORDSHD	Length of segment with akinesis or dyskinesis (NLOL)
11	FLVNP	1 = LV data available for non-protocol catheterization 0 = no data
14	EDVNP	End diastolic volume
14	ESVNP	End systolic volume
14	STKVNP	Stroke volume
F5.1	CONP	Cardiac output
14	RVGEFNP	Ejection fraction
F10.4	POSLADNP	Hypokinesis single vessel LAD
F10.4	POMLADNP	Hypokinesis multiple vessel LAD
F10.4	POSRCANP	Hypokinesis single vessel RCA
F10.4	POMRCANP	Hypokinesis multiple vessel RCA
F10.4	PRSLADNP	Hyperkinesis single vessel LAD
F10.4	PRMLADNP	Hyperkinesis multiple vessel LAD
F10.4	PRSRCANP	Hyperkinesis single vessel RCA
F10.4	PRMRCANP	Hyperkinesis multiple vessel RCA
12	YEARNP	Date of non-protocol cath
12	MONTHNP	
12	DAYNP	
F10.4	HYPONP	Hypokinesis non-protocol
F10.4	HYPERNP	Hyperkinesis non-protocol
13	ONESDNP	Length of segment with hypokinesis more than -1 SD (NL1L)
13	TWOSDNP	Length of segment with hypokinesis more than -2 SD (NL2L)
13	CHORDSNP	Length of segment with akinesis or dyskinesis (NLOL)